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DRUGS IN THE 1990'S: EMERGING TRENDS; THE CHALLENGES FACING THE DRUG ENFORCEMENT ADMINISTRATION, THE JUSTICE DEPARTMENT, AND THE COAST GUARD

Y 4. G 74/7: D 84/36

Drugs in the 1990's: Emerging Trend...

HEARING

BEFORE THE
INFORMATION, JUSTICE, TRANSPORTATION,
AND AGRICULTURE SUBCOMMITTEE
OF THE
COMMITTEE ON
GOVERNMENT OPERATIONS
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS

SECOND SESSION

MAY 25, 1994

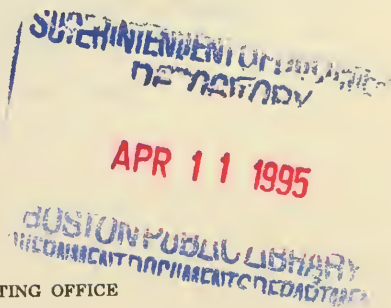
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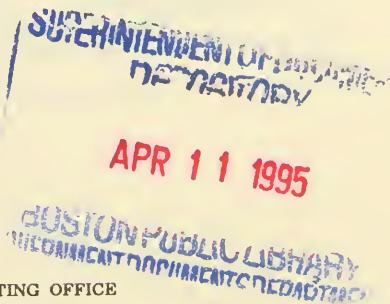
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DRUGS IN THE 1990'S: EMERGING TRENDS; THE CHALLENGES FACING THE DRUG EN- FORCEMENT ADMINISTRATION, THE JUS- TICE DEPARTMENT, AND THE COAST GUARD

WEDNESDAY, MAY 25, 1994

**HOUSE OF REPRESENTATIVES,
INFORMATION, JUSTICE, TRANSPORTATION,
AND AGRICULTURE SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
*Washington, DC.***

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 2203, Rayburn House Office Building, Hon. Gary A. Condit (chairman of the subcommittee) presiding.

Present: Representatives Gary A. Condit, Karen L. Thurman, Bart Stupak, and Craig Thomas.

Also present: Representative Al McCandless.

Staff present: Edward Armstrong and John Edgell, professional staff members; Aurora Ogg, clerk; and Diane M. Major, minority professional staff, Committee on Government Operations.

OPENING STATEMENT OF CHAIRMAN CONDIT

Mr. CONDIT. If I could have your attention, we will begin the hearing this morning.

Today we will begin the subcommittee's investigation into drug use in the nineties and the new emerging drug trafficking patterns. Subsequent hearings are planned to focus on Federal agencies involved in the Federal drug effort.

This subcommittee has a long tradition of examining drug interdiction, trafficking, law enforcement assistance, and general oversight of the DEA. It is my hope that these hearings will identify new and emerging problems and make constructive recommendations on how the Federal Government can do a better job at combating drug smuggling and use. We believe this is an extremely important issue.

It is important to note that the United States spends over \$20 billion annually to combat our drug problem. We have 5 percent of the world's population and consume two-thirds of the world's supply of cocaine.

According to the Office of National Drug Control Policy in its recently released pulse check report, since 1992 the use of both powder and crack cocaine has remained stable, with most police departments continuing to list coke as their primary problem.

Heroin is making a comeback. Due to the high purity of heroin available and a decrease in price, smokable heroin is gaining in popularity.

Marijuana use, which declined during the mid and late 1980's, is being used increasingly by teenagers.

Also making a comeback are LSD, PCP, and mescaline. Use of meth, both tweek and ice, also recently is gaining popularity.

While cocaine use peaked in 1985, cocaine overdoses have increased dramatically from 1986 to 1992. The gains that we have made in cocaine use have mainly been with recreational users.

With production at record levels and falling prices, snortable and smokable heroin becoming available. Recreational users will most likely be the target of the heroin dealers. One of the questions we must confront today is whether we will face a heroin epidemic like the cocaine epidemic of the 1980's.

Drug users and addicts continue to have a profound impact on virtually all aspects of American society. We cannot pretend to address the problem of crime, welfare reform, AIDS transmission, homelessness, domestic violence, unemployment, and educational reform without coming to a greater understanding of the fundamental problem of drug addiction and abuse in our Nation.

Drug abuse remains one of the most pressing and costly domestic challenges. This subcommittee and the witnesses we have assembled today share a commitment to seek constructive solutions to this fundamental problem.

I would like to turn to my colleague from Wyoming, Mr. Thomas, for any opening statement that he would like to make.

Mr. THOMAS. Thank you, Mr. Chairman. Thank you for calling today's hearings. I hope this will be the first in a series of hearings on the National Drug Control Strategy and its implementation.

For the first time in 10 years, drug use is on the rise among adolescents, according to an annual high school survey conducted by researchers at the University of Michigan. If our young people are to be leaders of tomorrow, they need to hear a clear and consistent message that drug use is dangerous, wrong, and criminal.

The reason people flirt with the idea is because the consequences are small, and as a result the risk is acceptable. The National Drug Control Strategy that was released in February sends the message that in order to receive help you must first be a hardcore drug user.

Rural States like Wyoming are fortunate not to have the severe drug problems and related crimes seen in some parts of the country. However, we too are beginning to see the increased trends in illegal drug use. Rather than wait until casual users become hardcore, our resources would be better spent preventing drug use becoming serious in the first place.

Treatment and prevention have their place in the battle against crime and drugs. However, interdiction and domestic law enforcement should play an important role in the National Drug Control Strategy, just as important as reducing the demand for illegal drugs.

It is for this reason that I am disappointed in the administration's proposal to cut more than 100 drug prosecution positions in the U.S. attorney's office, to reduce the mandatory minimum sen-

tences for drug trafficking and related crimes, and to reduce drug intelligence programs, among others. Because drug use and crime are so closely linked, it is time the administration stopped sending mixed signals. The fact is, casual use is not OK, because if left unattended, it becomes a long-term problem for society.

If the administration wants to create a productive work force and reduce rising crime rates, it needs to beef up the consequences for illegal drug use. It needs to send a strong message that we will go after international and domestic drug traffickers. At the same time, the message needs to be heard loud and clear that illegal drug use is not only harmful but dead wrong. Today's hearings will provide answers to how we can best advocate this message, and I look forward to hearing from our witnesses.

Thank you, Mr. Chairman.

Mr. CONDIT. Thank you Mr. Thomas. We appreciate it.

Mrs. Thurman.

Mrs. THURMAN. No statement, Mr. Chairman.

Mr. CONDIT. Mr. McCandless, we are delighted to have you with us today.

Mr. MCCANDLESS. Thank you, Mr. Chairman, for your invitation. I kind of miss the activities of this subcommittee, having served on it for quite a number of years, and particularly the importance of the subject before us today.

A great deal of time and effort has been invested on the part of the former members of this committee and current members of the subcommittee on the subject of drugs. We talk about our foreign policy with respect to parts of the world; we talk about our domestic problems; I don't see anything, anywhere, any place that has more of an impact upon every phase of the society in which we live than the drug problem and what it creates in the way of agony, cost, waste, and human lives.

As an example, Mr. Chairman, in my district in California, which represents most of Riverside County outside of Los Angeles, the sheriff, who I have known quite some time, tells me that 80 percent of all of the criminal activity that he is involved with, in one way or another, has a drug base to it. I think that, in itself, is demonstrative of the problem, and I feel that we need to review our strategy, we need to take another look at where we are going, revisit the subject, and move forward with a great deal more diligence than currently appears is taking place.

Thank you very much for your invitation.

Mr. CONDIT. Thank you, Mr. McCandless.

There is, I guess, kind of a belief among some of the people on this committee and some of the staff people that since I have become chairman, that this committee has taken kind of a country western attitude, and it has, because I am a big country and western fan, and as our first witness today—we are delighted to have—and—he has made a great effort to be here—Mr. Larry Gatlin. A grammy award-winning song writer and recording artist. He is also a Broadway star. I have personally enjoyed his music over the years.

Maybe I will ask him the question. I understand the word was that every album you produced, you actually wrote all the music

and songs on those albums, which impresses me greatly because I have heard most of those songs. We are delighted to have you here.

If you will come forward Larry, we have a policy—I don't want to alarm you—we have a policy of swearing all the witnesses in. So if you will bear with me, raise your right hand. Thank you.

[Witness sworn.]

Mr. CONDIT. Mr. Larry Gatlin, we are honored to have you, sir.

STATEMENT OF LARRY GATLIN, THE GATLIN BROTHERS, RECOVERING SUBSTANCE ABUSER

Mr. GATLIN. Thank you, Mr. Chairman and members of the committee. I appreciate it very much, glad to be here. Considering some of the things I have done in my life, believe me, I am glad to be anywhere, so that is a miracle in and of itself.

My name is Larry Gatlin. I am a country singer, a member of the grand ole opry, member of the Country Music Association, the Academy of Country; I am a BMI song writer; as you mentioned, I have been to Broadway. More importantly for the matters at hand this morning, I am Larry Gatlin; I am a drug addict and an alcoholic.

Usually when I go and tell this little story, I intermingle little humorous anecdotes and things that have happened to me along the years, but in writing up this story I decided that, for the sake of time and clarity, that I would put it all down on paper. So if you will bear with me, I would like to read for you what it is that I have brought for you this morning.

As I said, my name is Larry Gatlin; I am an alcoholic and drug addict. When I was a young man growing up in Odessa, TX, if you had told me that I would introduce myself in this manner, I would have told you that you were insane. Well, insanity is part of this story, but I am the one who was insane. This disease of alcoholism and drug addiction is a very insidious, baffling, cunning, and powerful disease. My story is proof of that fact. It is a horrible story with a happy ending, and I will give it to you using the geographical background as the basis for the story. So here goes.

Odessa, TX, 1964. I had my first drink of alcohol with some of my teammates from the Odessa High School football team. The stuff tasted awful, but it made me feel good. Even though I got deathly sick from—get this mixture—gin and Dr. Pepper, I couldn't wait to try it again. As I said earlier, this is an insidious disease. Thus began my 20-year love/hate relationship with alcohol and other drugs. Thus the insanity began.

Fast forward to Houston, TX, 1966. I enrolled at the University of Houston in September 1966. I immediately began running around with my buddies on the football team who were much more knowledgeable in the ways of drinking and drugging than I was. My taste for alcohol began to change. I actually developed a liking for the filthy stuff and could not wait for the weekend beer parties at the local frat house and, believe it or not, the parties thrown by several of the breweries in the Houston area.

While attending the University of Houston, I gradually began experimenting with other drugs—marijuana, amphetamines, and pain killers. I was 21, healthy, full of life, and, in my own mind, invincible. Thus the insanity continued.

Fast forward to 1971, Nashville, TN. In 1971 my wife Janis and I moved to Music City, U.S.A., Nashville, TN, where I was immediately thrown into rather interesting company. Wonderful, talented, brilliant, singer-song writers, performers, musicians, drug addicts. We wrote songs together, we played concerts together, we did drugs together. We thought we would live forever and that we were invincible. These people are some of my dearest friends to this day, the ones who have survived, and thank God most of them have embarked on a road of recovery.

My life over the next 13 years was heaven and hell at the same time. I became an internationally known musical star as the lead singer of Larry Gatlin and the Gatlin Brothers. We sang all over the world to millions of people, from the White House to the county fair in Eldon, IA, and we had a wonderful time.

But there was a dark side to these 13 years. My addiction to alcohol and drugs got increasingly worse. My life became a big lie. I was physically, mentally, emotionally, and spiritually bankrupt. My friends and family begged me to get help, and I told them very simply to mind their own business, that I worked hard, and, by God, I was going to play hard.

My friend, Coach Darrell Royal, told me one day, "Cowboy, you are my friend and I love you, but you are a sick puppy dog. Let's go get some help." I told Darrell that I could do it on my own, that I wasn't going to some damn loony bin and have shrinks dissect me like a bug under a microscope.

Fast forward to Dallas, TX, November 28, 1994. Larry Gatlin, good ole boy from Odessa, TX, found himself crawling on the floor of a hotel room picking lint out of the carpet and putting it into a cocaine pipe. I crawled into the bathroom on my hands and knees, accidentally looked into the mirror, and I saw what looked like to me what I think the Devil himself must look like. It was me. I said, "God, if you don't help me, I'm going to die," and God did help me.

I got home to Nashville, TN, where I called Coach Darrell Royal and told him that I was ready to go.

Fast forward to Orange County, CA, December 9, 1984. On that day, my friend, Coach Darrell Royal, and I walked through the front doors of the care unit hospital of Tustin, CA. Dr. Joe Pursch, one of the world's leading experts on addiction, met us there, and I began my 28-day recovery program.

By the grace of God, one day at a time, with the help and prayers of my family and friends and a program of recovery, I have not had a drink or drug for those intervening 9½ years.

Fast forward to Washington, DC, May 25, 1994. I am alive, and I am healthy, I am sober and straight, and I am grateful beyond words to my higher power who I choose to call God. When I was drunk and loaded, I had problems with my wife, I had problems with my kids, I had problems with money, I had problems with the fans, I had problems with life itself.

Well, now that I am sober and straight, guess what? I have problems with my wife, I have problems with my kids, I have problems with life itself, I have problems with money. I have all the exact same problems that I had before. There is a wonderful difference. I don't drink alcohol, and I don't do drugs over those problems.

While some folks may think correctly that I am a bit zany at times and perhaps even a little bit too festive at times and, as we say in Texas, sometimes I seem like I'm a cup and saucer short of a full place setting, I am no longer insane, I am sane today. What a miracle. That is a miracle of God, and, I repeat, I am grateful to God for this miracle.

I thank you all, and I am grateful to be here this morning. Thank you very much.

Mr. CONDIT. Thank you, Larry.

Larry, is it your impression that the public attitude has changed on drug use?

Mr. GATLIN. Mr. Chairman, I believe we are much more aware.

You know, thank God for a wonderful lady named Betty Ford, who a few years ago came out of the closet, so to speak, with her own alcoholism and her addiction to pain killers and different things, the public awareness has been elevated.

I think when a young basketball player from the University of Maryland died the first time he ever smoked cocaine—Len Bias died the first time he ever used it—here was a man in the prime of his life, athlete—I think those kinds of things, the publicity that those get have—have gotten—excuse me—have increased our awareness of the problem.

However, it is my opinion—and that is all it is—that our attitudes concerning drugs and alcohol—and I would put alcohol in there, and please bear with me; that is part and parcel of this disease and of this problem. People sometimes try to separate them out. They are inseparable, they are hand in glove, they go together. So I still think that this country is very permissive in its attitudes.

Only recently has it become fashionable for us to spout words like, "Know when to say when." America very rarely in anything knows when to say when. We go to the wall, and then we back up. We are more aware. Whether we have changed our attitudes or not, I question that, I really do.

Mr. CONDIT. What role should the Federal Government play in all this? Do you have any suggestions on that?

Mr. GATLIN. Well, I really believe that, you know, part of that "promote the general welfare, provide for the common defense," that playing hard ball with the countries who produce these chemicals for our kids, I think we ought to give Governor Pete Wilson a hand and these fellows in California to try to see if we could eradicate the No. 1 cash crop of the great State of California, which is marijuana. You know, let's play hard ball with the people who are selling poison to our children.

I am not a politician, I am not a military strategist, but if you don't go at least to the source of where it is coming, and play hard ball with those people, it is going to continue to come into this country, because our efforts at interdiction, while Mr. McCandless is correct, we must continue that, we are never going to keep all of it out of this country.

Mr. CONDIT. What is your advice to us on how we get the message across to young people today?

Mr. GATLIN. Well, I believe with all of my heart that it is at least equally important as reading, writing, and arithmetic. You know, these kids sit here, they see movies, they see television constantly,

and thank God the folks in Congress have started to address those questions. They are inundated. You can buy drugs on every corner—not every corner, that is an overstatement. But right now, as an expert on this subject, I can take people and within 1 hour, maybe less, I can find us just about whatever we want in this city, and so can the other people.

I would make it not an addition to the curriculum, not have a policeman come in once a month and tell these people that they can be thrown in jail, it is more important than that. I would make it a basic integral part of every kindergarten, preschool, first grade, middle school, and high school in this country to tell people and educate these young people about what is happening to them because, God knows, the other side of it is trying to kill them and they don't care a damn thing about them.

Mr. CONDIT. Mr. Thomas, do you have any questions of Mr. Gatlin.

Mr. THOMAS. Just let me thank you for coming forward with your story. It takes courage to do that.

Mr. GATLIN. Thank you, sir.

Mr. THOMAS. And people like you will have great impact on what we are doing, and I thank you very much for doing that.

Mr. CONDIT. Mrs. Thurman.

Mrs. THURMAN. Thank you.

I just want to again tell you thank you very much for being here, and I hope that you take the time to tell the children what you have told us, because I think that they listen to people like yourselves in getting the story out and they pay attention not always to their parents but to people that they respect and they have seen to be in stardom of some sort. So thank you for that.

Mr. GATLIN. Thank you, Mrs. Thurman.

As an aside, as just a comment, I have spoken to maybe 50 to 60 schools, high schools, elementary schools, civic groups over the country in the years that I have been sober. A very interesting thing happened in Pasadena, TX. I sat with fourth, fifth, and sixth graders, and I asked how many of the fourth graders had ever had alcohol. Well, it was about maybe 25 or 30 percent. I asked the fifth graders; it was 50 percent. I asked the sixth graders, and it was 90 percent. I was shocked. As a recovering alcoholic and drug addict, I think that needs to be addressed, I really do, and thank you.

Mrs. THURMAN. Thank you.

Mr. CONDIT. Mr. McCandless.

Mr. MCCANDLESS. Thank you, Mr. Chairman.

One of the things that is a key element of this is the need to educate and rehabilitate along with the interdiction that we have talked about. We are not going to eradicate drugs totally, but if we can bring them down to a controlled level, then we are going to make some progress.

One of the things I would like to ask you about is your observations as to the availability of rehabilitation programs for the average person. Are they available if a person wants to try to find the answer to their problem?

Mr. GATLIN. Mr. McCandless, that is a wonderful question, and you have hit to the core of the problem. When I went to treatment

in 1984, the cost of my treatment was \$13,000. I stayed for 28 days. Fortunately, I could afford that. However, at that point in time, my insurance was such that it paid for it.

A very good, dear friend, just to cite one example, Mr. Bill O'Donnell, who runs the Sierra Tucson Treatment Facility in Tucson, AZ. It is one of the very best state-of-the-art wonderful people, they know what they are doing, their success rate is wonderful. The problem is, it is a private company. Mr. O'Donnell is the CEO of this company. He is trying to keep his doors open. I am admittedly naive as to all of the ramifications of health care and all the things that the heated debate is right now. I do know that my friend had to write off almost \$1 million of care last year from insurance companies who were paid premiums and who literally kicked—he had to make the people leave or give them free care.

That is foreign to me, that someone would have paid their premiums and their kids not get to go to treatment. It is very expensive. He has to keep the doors open. Somebody has to cook the food—you know, all the things that are part and parcel to this.

To answer your question, treatment is, not in my opinion—I am not an expert on this part of it—readily available to people. It is very expensive. People have to get paid.

Two years ago, I read the report, the budget—you all know what I am talking about, right? Some kind of budget report that you all probably helped to write. Of the \$13 billion spent by this Government—by that Government at that time, on this problem, \$11 billion was spent for interdiction, \$2 billion was spent for treatment.

I respectfully submit to this committee and to these people this morning, if we stopped every ounce of cocaine from coming into this country, if we stopped every ounce of heroin from coming into this country, we had best call out the National Guard to guard every pharmacy, liquor store, beer joint, and cocktail lounge in this country because when drug addicts and alcoholics want to feel better, they are going to do something and find something to do it.

So treatment of these people hand in hand with interdiction—I'm not saying that we don't do it—those of us in the recovering community believe that that percentage is a little bit askew, \$11 billion to \$2 billion. It seems like we may have the tail wagging the dog a little bit. I don't believe treatment is readily available to people, to all people who need it.

In my opinion, it is the No. 1 health care problem in this country. It is very sad. I could afford it. I went and did it, and, by the grace of God, it worked.

The third day I was in there, Dr. Joe Pursch had to tell a young lady who had been there 4 days that she had to leave because her insurance was up. I think that is a crime. I think that is a travesty of justice. And I get a little passionate about these things, and please forgive me.

Mr. MCCANDLESS. Thank you for being with us this morning.

Mr. GATLIN. Yes, sir. Thank you.

Mr. CONDIT. Larry, thank you very much. You have done a great service to this committee and to our factfinding mission on some solutions to this problem. You have done a great service to the country.

Mr. Stupak had a question.

I am sorry, I thought you were going to leave, Bart.

Mr. STUPAK. Yes, you are right, I do have to leave. At 10 o'clock I am marking up in the Coast Guard Subcommittee in which most of the interdiction of drugs in this country falls, on the Coast Guard.

Mr. GATLIN. Yes, sir.

Mr. STUPAK. It is sort of a crazy place to have it. And the last crime bill we did pass, it was a 60/40 approach to crime prevention and treatment, or I should say law enforcement and prevention.

But on your comments, your last comments here, would you advocate then that in any crime package that we debate as a Nation, as a part of the basic national health care benefit package, that drug and alcohol treatment be a basic standard part of that standard package, 30-day inpatient, outpatient counseling?

Mr. GATLIN. Yes, sir, I would. I am not one of those that believes that the Government is supposed to take care of me cradle to grave, but I do know that one of the highest rates of recovery from alcoholism and drug addiction was what was formerly Yugoslavia. On a second arrest for drunk driving, you had no choice, you went to treatment. You know, it is that simple. We have heard a lot about three strikes and you're out. Well maybe it ought to be two strikes and you're in, you know. Put them in, get them off the highways, let's do something about this. So I would strongly support that.

Mr. McCandless hit it, it absolutely superimposes itself on every other question of our economy, of every socioeconomic question that we have, of racial questions, of poverty questions, of welfare questions. We try to separate and pigeonhole these things neatly, and we can't do it. It absolutely underscores every bit of it. So the 60/40 approach, that is much better than 11 to 2. What percentage is that? Anybody, quick? I don't know.

Mr. STUPAK. Eighty-twenty.

Mr. GATLIN. Eighty-twenty, close enough.

So in my opinion that is much better, yes, sir.

How can we take this question where 50,000 people die in car wrecks from the alcohol, the people dying on the streets from overdoses? I would strongly support that and believe that is absolutely the right approach.

Mr. STUPAK. Thank you.

Mr. CONDIT. Mr. Gatlin, thank you.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. CONDIT. I apologize to you.

Mr. STUPAK. That is all right.

Mr. CONDIT. Mrs. Thurman wants to ask a question.

Mrs. THURMAN. Yes, they brought up some issues.

You know, one of the things that we always hear is that these programs don't work—you know, we put a lot of money into them, people go for 28 days, they come out, and they start a life all over again. In your case it has worked. What do you think for you was the difference of not going back to that life?

Mr. GATLIN. Many years ago, Henry Kissinger said it is amazing how simple decisionmaking becomes when one is left with no alternatives. I was left with no alternatives. One, get straight or die. That was basically it. With the help of my wife, Janis and our kids

and our family, and a resurgence of my faith in God that I choose to call my higher power, it did work for me, and to those who say that it doesn't work, I would say this. Some are going to fall through the cracks, Mrs. Thurman; we can't catch them all. But what is the number that we are looking for? Is it 20 percent? Is it 25? I don't know. But I do know this. It is a better alternative than let them all, you know, go to hell in a yellow bucket, and that is what is happening to this country as far as this war is concerned.

It does work. There are millions of people. Betty Ford is proof that it works. Larry Gatlin is proof that it works. Johnny Cash is proof that it works. There are thousands of these stories that we could tell. There are Members of the House of Representatives and the Senate that are living proof that it works. I met them on the White House lawn yesterday, 2 years ago at the congressional barbecue, that they came up and confided to me that they were members of this little group of recovery. It does work.

No, it doesn't work every time. Which government program does? Which program, period, does? My God, what are we looking for? Let's say 50-50, 60-40.

It doesn't mean, you know, to sit—what is the deal? It is better to light one candle than to sit in the dark and curse? So let's light the candle. Let's give people a chance to get recovery. It does work. Crawling on the floor picking lint out of a freebase pipe and sitting here with hair combed and a shaved face and a tailor-made suit and wearing a Rolex—that is proof that it works. I was broke. It was over for me, and the period—the program of recovery does work, and I am grateful for that, I really am.

Mrs. THURMAN. But for some of these people, because you mentioned your family and having that kind of core group that was there or the coach that kind of took you by the hand—for some others, do you think some of the focus groups or the, you know, groups that they get together, kind of support groups—I mean are those something that we should be also making sure of happening in our community to help people that don't have the same kind of family system that you had?

Mr. GATLIN. Well, you know, we have tried so many different things. We have tried methadone programs. We have tried—you know, we have tried everything—psychiatrists, and part—you know, maybe that is part of the help. I know that my program of recovery includes certain steps that I have been advised to take.

If you are a member of the press here today, I would ask you to not publicize this part of my talk. I do go to alcoholics anonymous meetings; I read the 12 steps. We have an anonymous program at the level of press, radio, and TV. I am not ashamed of it at all, to talk to you people openly about that. That is just one of the traditions that I try to respect.

Year in and year out, day in and day out, that program of either cocaine anonymous, alcoholics anonymous, drug—narcotics anonymous, it is really the only thing that has ever really worked in any real numbers. I have heard the No. 50 percent, that people who will really work the program—there is a little deal in the front of our book that says, "Rarely have we seen a person fail who thor-

oughly followed our path," and if you really want that and want what I have and want it bad enough, you can get it.

Obviously, it helped to have a loving family. Obviously, it helped to have a background raised in a spiritual home. All of these things are things that I am grateful for. But I have seen people who had absolutely no background in that and had no family, who could come in and take certain steps and meet once or twice a week with people who were like minded who have made this thing work. I have seen it work, and I believe it does. Like I say, some of them are going to fall through the cracks.

Mrs. THURMAN. Mr. Gatlin, I thank you for that.

Mr. GATLIN. Thank you.

Mrs. THURMAN. And I hope that the press will respect what you ask.

Mr. GATLIN. Thank you. I appreciate that.

Mr. CONDIT. Thank you very much. You have done a great service to this committee, and I appreciate that.

Mr. GATLIN. God bless. Thank you for letting me come.

Mr. CONDIT. Thank you.

Mr. GATLIN. I have to catch an airplane. Is that OK?

Mr. CONDIT. Absolutely. I understand.

Mr. GATLIN. You don't swear me out or anything?

Mr. CONDIT. No, no. You are done, and we appreciate it.

I will be right back.

Mrs. THURMAN [presiding]. We are going to swear the next panel, second panel: Mark Kleiman, Peter Reuter Mathea Falco, and Steven Flynn, and Herbert Kleber.

Mr. CONDIT [presiding]. I apologize.

Do you want to swear them in?

Mrs. THURMAN. I was going to, but I will let you do the honors.

Mr. CONDIT. I apologize.

Would you please rise, and I'll swear you all in.

[Witnesses sworn.]

Mr. CONDIT. We appreciate you all being here this morning, and you have all been here for the first witness, and we appreciate your patience.

We will start with Mr. Kleiman from Harvard University.

If you want to make any introductions.

STATEMENT OF MARK KLEIMAN, HARVARD UNIVERSITY

Mr. KLEIMAN. Thank you, Mr. Chairman, members of the subcommittee. It is an honor to be here to discuss the potential contribution of the Justice Department, Drug Enforcement Administration, and the Coast Guard, to reducing drug abuse and drug-related harm.

The prepared testimony that was distributed is somewhat off topic. It concentrates on the contribution of drug policy more broadly conceived to a narrower target, drug-related crime, and I submitted it as a model of the sort of analysis that it seems to me ought to be pursued in this area and is too rarely pursued.

To start, that paper lays out a set of goals on the hand and a set of tools on the other and systemically asks how the tools could be employed in the service of the goals. That, I regret to say, is not the process by which Federal drug enforcement strategy, has been

made, or criticized, for that matter. The process instead has been one of one, announcing attractive sounding but unattainable goals—a drug-free America, victory in the war on drugs, keeping foreign drugs out, two, inventing and pursuing plans without any careful account of what useful results they would lead to—zero tolerance, the target kingpin organization strategy, domestic marijuana eradication, three, missing major potential contributions—violence related to drug trafficking has not been a target, four, missing strategic turning points, the growth of cocaine from 1975 to 1982, the growth of the heroin market from 1985 to the present, and five, achieving false victories.

The massive decline which has been referred to this morning in the number of cocaine users, particularly the massive decline in the rate of initiation, doesn't seem to have solved the cocaine problem, as it was promised that it would. An even clearer case is marijuana, where enforcement has succeeded magnificently, I think beyond the imagination of most of us, in raising the price of marijuana, with, as far as one can tell, very little apparent benefit, even before this recent upturn.

The need, I think, is for a strategic analysis of drug policy based on the market nature of the problem. The question always has to be asked, if we do X, what will the drug buyers and drug sellers do in response, and with what effect?

The notion that, since this is a law enforcement effort, putting a large number of bad guys in jail is itself a victory.

It is also worth noting the folly of using the survey numbers and other drug statistics as scorecards for partisan purposes, to prove that one or another administration has failed or succeeded. There has been a lot of that around. Those numbers move for their own reasons largely unrelated to Federal policy, and once you back an administration into a corner, saying "you have to make these numbers move in the right direction, you wind up with some of the mistakes we have seen in the past several years."

In the rest of my remarks I will obey the conventions and ignore America's two largest drug problems, alcohol and nicotine, but, having made that decision, I couldn't pass by a remark of Mr. Gatlin's which I thought deserved attention. His first drug—first illegal drug—was alcohol; it was illegal because he consumed it as an adolescent. That remains the pattern. The tiny increase in the number of high school students who self-report having used marijuana at one time or another remained dwarfed by the fact that one-third of high school seniors—this ignores the dropouts, who are more likely than average to be already on the casualty list—one-third of the high school seniors report having had a drinking binge in the last 2 weeks. That, Mr. Chairman, I would submit, is the national drug problem, and anybody who says he is for the war on drugs and against higher beer taxes is not telling the truth.

But to get back to our conventions, let me concentrate on the smaller half of our drug problem, the one I know something about, the illicit drugs and, in particular, what can be done about them at the Federal level. There are two major sets of programs that this subcommittee has under its jurisdiction. One is the Federal enforcement effort, or at least the part of it represented by DEA and the Coast Guard. In that area there are two things to be done right

now. One is to direct attention at heroin, which is the rising problem. The prospects of improving the cocaine situation in this country by additional enforcement effort are quite bleak. The cocaine market is so large that no plausible enforcement effort will change it greatly.

Managing the cocaine problem now means learning how to manage the decline of today's heavy cocaine using population. At this late stage of the epidemic, enforcement is not the primary means of control.

In the case of heroin, on the other hand, the question is how to confront a catastrophic price collapse. This decline in heroin prices from 1985 to date matches the price decline in cocaine from 1975 to 1985. The question facing us is how to keep that price collapse from having a comparable impact on the number of users and the size of the problem? If the drug is easily available at retail in a large number of cities, there is going to be a huge problem; we are already seeing on the west side of Chicago the development of open heroin dealing of a kind that hasn't been seen since the early 1980's.

Therefore, directing Federal enforcement resources away from other things and toward heroin now seems called for.

The other thing that the Federal agencies can do, and DEA is beginning to do this, is to start to pay attention in a serious way to the violence incident to drug dealing. That has always been a major rhetorical point in the discussion of this issue, but when you look at the actual policies of DEA, and the other Federal drug law enforcement agencies in targeting organizations and individuals for enforcement action, their engagement in violence has not been a criterion. The criteria have been the drug, the quantity, the individual's role in the organization, so that two identically sized cocaine enterprises, one of which uses a lot of violence and the other of which does not use very much violence, have the same risk of being targeted. In fact, probably the more violent organization has been less likely to be a target since it is harder to develop an informant, against such enterprises. Changing this situation will require changing the way we keep score for Federal drug law enforcement.

The other major program that this subcommittee has oversight over is the Department of Justice grants program, the Byrne grants and now presumably the grants that will come out under the crime bill.

There has been a lot of discussion about the proposed increase in the number of police officers. Most people who follow law enforcement at a policy level do not believe that a scarcity of police officers is the No. 1 problem facing American law enforcement. If you ask a police officer what the worst thing is about his or her job, the response is always the same: "Seeing the bad guy back on the street before I've got the paperwork done." That suggests to me that the scarcity is of prosecutors, judges, public defenders, and corrections capacity and adding police officers to that mix is not obviously the right thing to do.

However, if those police officers and those resources can be used to speed the transformation of the strategy of policing toward community based approaches that could be a huge contribution. There

is evidence that certain community based antidrug strategies can have a huge impact without generating more arrests than the courts can handle.

The next question is, how can the Justice Department, which will be administering this program, make sure that these resources are being employed as Congress intends that they be employed toward community policing. Let me make one suggestion along those lines.

Changing the promotional exams within police departments to focus on community policing strategies would make an enormous difference in the incentives facing police officers and police supervisors in doing their work. Unlike what is actually happening on the streets, is something that could be effectively monitored from Washington.

The diversion of the Byrne grant program funds to primarily support multijurisdictional task forces may not have been good policy. We have now seen the power of the people getting money under those programs to defend their flow of funds. A serious look at those multijurisdictional task forces to see whether they are, in fact, doing the drug law enforcement that best serves national goals would be called for.

The other issue that I think ought to be raised about the DOJ grants program is that it should not be entirely concentrated on the front end, the investigative end, of the criminal justice system. We need more attention to the back end. Here let me offer one practical proposal: coerced abstinence for drug-involved offenders.

There are in this country somewhere between 2 and 3 million people who use a lot of cocaine and/or a lot of heroin and who support their drug habits primarily with criminal activity. We know about them because they get arrested a lot. My calculations suggest that about three-fifths of all the cocaine that is sold in this country goes to that relatively small group of people. If that is right, then we have an enormous demand-side opportunity to control the drug problem. But it is not, I would submit, primarily a treatment opportunity.

In the colloquy with Mr. Gatlin, a number of members asked what was it that accounted for his success in by contrast with recovery, the failure of so many others. I would submit the availability to him not merely of a strong family and an expensive treatment program, but the prospect of a tailor-made suit and a Rolex watch and stardom as the result of his recovery probably contributed to that outcome.

The poorer the prospects someone has once the bottle or the needle or the crack pipe are no longer an issue, the poorer the recovery statistics.

On the other hand, people who are on probation or parole who are subject to a different kind of intervention. Their continued freedom on the street could be made conditional on their continued freedom from illicit drugs, and that could be monitored by regular testing.

The current programs of probation and parole departments feature very irregular testing, and very irregular sanctions, but when the sanction does happen it is likely to be quite severe; somebody could be sent back for 6 months, 1 year, even to finish a long sentence as the result of the sixth or seventh or eighth dirty test.

I submit that it would be much more intelligent to do testing very often for all drug-involved offenders, to have sanctions every time a violation is detected, but have those sanctions mild, a couple of days in jail, a week in jail, recognizing the relapsing nature of drug addiction with a firm insistence that it has got to end. There are a few small pilot programs that suggest that the vast majority of people who have serious drug problems can and will stop under that sort of pressure.

In one county in Oregon before the probation department started giving tests as if they meant it, 40 percent of the people tested positive; 8 months later that rate of positive test was down to 10 percent. A grant program that supported an aggressive program of mandatory abstinence for drug-involved offenders on probation and parole represents the only major opportunity before us to substantially reduce the illicit drug problem. Nothing on the enforcement side has a comparable chance, I hope that we will develop such programs, test them, evaluate them, and if they turn out to work, make them a national model.

[The prepared statement of Mr. Kleiman follows:]

DRUG ABUSE CONTROL POLICY FROM A CRIME-CONTROL PERSPECTIVE

David Boyam

BOTEC Analysis Corporation
and

Interfaculty Program in Drug Policy, Harvard University

Mark A.R. Kleiman

John F. Kennedy School of Government, Harvard University
and

Interfaculty Program in Drug Policy, Harvard University

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Discussions about crime control—at cocktail parties, in classrooms, and on Capitol Hill—inevitably turn to the subject of drugs. For one thing, violence among drug dealers, who in inner-city neighborhoods appear to shoot each other (and occasional passersby) with frightening regularity, is at the heart of public anxiety over crime. Moreover, one of the few universally accepted propositions about crime in the United States is that active criminals are disproportionately substance abusers. In Manhattan, urine tests indicate that over three-quarters of those arrested have recently taken illicit drugs; in few major cities is the proportion less than half (National Institute of Justice 1993). A majority of jail and state prison inmates report that they were under the influence of drugs or alcohol (or both) at the time of their current offense (U.S. Department of Justice 1988, 1991).

For most Americans, such statistics, bolstered by images of urban drug killings, underscore the need for vigorous drug enforcement. They see drug trafficking as inherently violent, and drug use as a catalyst for criminal (and other delinquent) behavior, both through the inhibition-reducing and aggression-stimulating effects of intoxication, and the impacts on character and lifestyle of long term substance abuse. Since, it is widely believed, drug dealing and use lead to crime, enforcement efforts to suppress these activities will tend to reduce crime (Office of National Drug Control Policy 1994).

Others have reached a very different conclusion. In their view, it is drug policy, and not drug abuse, that is principally responsible for the observed drugs-crime connection (Nadelman 1988). Noting that many heavy users of illicit drugs commit crimes to finance their habits, they argue that prohibition and enforcement, which by raising the prices of illicit drugs make those habits more expensive, increase rather than decrease crime. As to violent crime among dealers,

that is even more obviously attributable to prohibition; when alcohol was an illicit drug, alcohol dealers settled their differences with firearms, just as cocaine dealers do today. But two contemporary liquor store owners are no more likely to shoot one another than are two taxi drivers. This reasoning has led a small but vocal minority of scholars and politicians to the conclusion that in order to reduce predatory crime, the drug laws, being criminogenic, should be repealed, or at least, that drug law enforcement should be radically cut back.

But "legalizers" and "drug warriors" alike ground their policy recommendations on partial and one-sided analyses of the relationship between drugs and crime. By creating black markets, prohibition can cause crime. But so too can intoxication and addiction, even when the underlying drug is legal. Thus, the answer to the question, "Do drugs, or drug laws, cause crime?" is, "Yes." The right question, from a crime-control perspective, is, "What set of drug laws, enforcement practices, and other policies would cause the least crime?" Of course, the crime-minimizing set of drug policies might not be the best set of policies, all things considered; other components of the public health and welfare are also involved. This present essay will, however, largely restrict itself to the crime-control aspects of the drug policy problem.

Even that problem is complicated enough, with causal chains that look like loops, evidence that remains stubbornly ambiguous, and policies whose effects, even as to their direction, may depend on difficult-to-predict details of implementation. It might turn out, for a given drug, that an intelligently-implemented prohibition would outperform any practicable system of legal availability, but that the less-than-ideal legal system that might actually emerge would outperform prohibition as it currently operates (or vice versa). More obviously, the crime

control costs and benefits of various drug policies are likely to vary sharply from drug to drug, even among those currently illicit, in somewhat complicated ways.

Nevertheless, we will attempt a systematic exploration of the myriad ways in which drugs and drug policy might, as a conceptual matter, cause or prevent predatory criminal behavior, and a review of what evidence there is about the existence and sizes of the logically possible effects. From there, we will turn to a review of drug abuse control policies, asking how legal status, the enforcement of drug and other criminal laws, and prevention and treatment programs, as applied to a variety of drugs, are likely to influence the levels of predatory crime. Lastly, we summarize what all of this suggests for the design of a crime-control-oriented drug policy.

THE DRUGS-CRIME CONNECTIONS

There seem to be three links between drugs and crime. First, there are the crime-facilitating effects of drug use itself: the intoxication and addiction that, in certain circumstances, appear to encourage careless and combative behavior. The second and third drugs-crime connections stem from policies of drug prohibition and enforcement: the crimes that attend the workings of the black market—violence among dealers and the corruption of law enforcement—and the crimes committed by users to obtain money with which to buy drugs.

Abuse-Related Crime

More crimes—and especially violent crimes—are committed under the influence of alcohol than under the influence of all illegal drugs combined (U.S. Department of Justice 1988, 1991). That alcohol, a legal and inexpensive drug, is implicated in so much crime suggests that

substance abuse itself, and not just economic motivation or the perverse effects of illicit markets, can play a significant role in crime. This hardly comes as a surprise. Anything that weakens self-control and reduces foresight is likely to increase lawbreaking along with other risky activities that promise immediate benefits and only the possibility of future costs (Wilson and Herrnstein 1985). And most of us have witnessed firsthand individuals who, when drunk or high, became reckless and aggressive, if not violent. Moreover, although aggressiveness is often an unwanted or at least unintended side effect of intoxication, those who intend to act aggressively sometimes become intoxicated to unleash their rage or to steel themselves for a violent encounter.¹

Yet the claim that drugs cause aggressive behavior is hard to prove. Of all psychoactive substances, alcohol is the only one that has been shown in behavioral experiments to commonly (but not always) increase aggression (Roth 1994; Reiss and Roth 1993). Heroin and marijuana, for example, seem to generate pacific rather than aggressive pharmacological effects (although short tempers are common during withdrawal from opiate addiction) (Martin 1983; Dewey 1986). In general, sweeping assertions about intoxication and aggression do not withstand scrutiny; the relationship only holds for people with certain types of personalities, using certain substances, in certain settings (Fagan 1990).

But the immediate effects of intoxication are not the only, or necessarily the most significant, effects of drug-taking on offending. Both the pharmacology of various drugs and the sociology of their acquisition and use may alter the behavior of heavy users in ways that increase their propensities toward offending, even when not under the influence. Chronic intoxication

¹ Alcohol, "Dutch courage" in the vernacular of the British Army, is sometimes referred to among American criminals as "liquid courage."

routinely hurts school and job performance, makes its victims more present-oriented and less likely to delay gratification, and damages relationships with friends and family. All of this, one would assume, makes violent and other criminal behavior more likely.

At least where cocaine is concerned, there is a chemical aspect to the matter as well. Stereotypes are rarely devoid of truth, and it is hard to dismiss the widespread belief among inner-city residents and drug treatment personnel that chronic cocaine and crack abuse produce paranoid, irascible behavior (Weiss and Mirin 1987; Post 1975). From a pharmacological perspective, cocaine and amphetamines are quite similar, and amphetamine abuse is clearly related to aggressive behavior (Bejerot 1970; Grinspoon and Bakalar 1985). Indeed, the difference in the levels of violence between the active street heroin markets of fifteen years ago and the active street cocaine markets of today seems to reflect in part the irritability that tends to characterize chronic heavy cocaine users. That in experiments cocaine has failed to consistently stimulate violent behavior is not conclusive here; if the connection between cocaine and violence is conditionally causal—meaning that cocaine use encourages violence, but only in particular contexts, and perhaps only after long term abuse—then experiments will necessarily have a hard time identifying a cocaine-violence link.

Crime Attributable to Drug Markets

In many cities, there is rampant violence among drug dealers. Because selling drugs is illegal, business arrangements among dealers cannot be enforced by law. Territorial disputes among dealers, employee discipline, punishment for stealing, informing, or not paying debts, and disagreements over the price, quantity, and quality of drugs are all likely to be settled by force.

Since dealers have an incentive to be at least as well-armed as their competitors, violent encounters among dealers, or between dealers and customers, will often prove deadly. Moreover, perpetrators of inter-dealer or dealer-customer violence are unlikely to be apprehended: enforcement drives transactions into locations that are hidden from the police, and victims, themselves involved in illegal behavior, are unlikely to file a report.

Drug dealers are more often and more heavily armed than they would be in other lines of work; dealing provides both the motivation and the wherewithal for weapons acquisition. In homicides that were considered drug-related in New York City in 1984, 80 percent of the victims were killed with a handgun, compared with only 47 percent in homicides that were not considered drug-related (Goldstein and Brownstein 1987). While guns can be a deterrent, perhaps reducing the number of violent encounters, their presence tends to raise the lethality of incidents that do take place. The net effect is probably a decrease in black eyes, an increase in fatalities (Cook and Moore chapter).

The arms race among drug dealers may spill over to other residents of drug-involved neighborhoods; survey reports of significant proportions of inner-city high school students carrying guns for self protection may represent evidence of such an effect (Sheley and Wright 1993). The process, once started, may be largely self-sustaining, and it is possible that a decline in cocaine dealing (or its elimination by legalization) would not greatly change the patterns of weapons acquisition and use that the cocaine trade certainly helped to establish. The vicious cycle of violence, fear, gun acquisition, more violence, and more fear may have taken on a life of its own (Kennedy 1994).

It is not clear how much of the violence among drug dealers is attributable to the drug trade itself, as opposed to the propensities of the individuals employed in it, or the economic, political, social, or cultural conditions of drug-impacted communities. Violent drug dealers tend to live and work in poor, inner-city neighborhoods, where violence is common, independent of the drug business. On an individual level, a willingness to engage in violence is part of the implicit job description of a drug dealer in many markets. And the logic of natural selection suggests that active dealers (as opposed to those who are dead, incarcerated, or scared out of the business) are those who were best able to use violence, intimidation, and corruption to protect their position.

Recent research suggests that urban violence is less directly related to the drug trade than it has been in the past, and that many violent incidents commonly thought to be drug related—because they occur between dealers, between members of drug-dealing gangs, or at a known dealing location (Goldstein et al. 1990)—are in fact not. Instead, the occasion of the dispute may be an insult, a woman, a sidelong glance, or seemingly nothing at all. Or it may involve gang territory; in studying street gang crime in Chicago from 1987-1990, Carolyn and Richard Block concluded that gang-motivated homicides were most often turf-related (gang turf, not drug turf), while only 8 of 288 homicides were related to drugs (Block and Block 1993). Observers note that the combatants are easily provoked—“live wires” is a common description—especially when they themselves are chronic crack smokers. (Spending one’s working life in a violent business, or living in a violent community, also contributes to having a short fuse.)

Other researchers stress the role of an inner-city culture in which respect is earned through violence, and where backing down from a confrontation is not only the ultimate loss of

face, but may actually increase future vulnerability (Ferguson 1993). "In fact, among the hard-core street-oriented," writes sociologist Elijah Anderson, "the clear risk of death may be preferable to being 'dissed' by another" (Anderson 1994, p. 92). Still others note that those involved in violent incidents typically have a history of delinquency (including violence) dating back to early childhood (Wasserman 1993). While data on these kinds of factors are difficult to assemble, Jeffrey Fagan came up with some revealing evidence in a survey of over 500 active drug dealers in the Central Harlem and Washington Heights neighborhoods of New York City. Fagan reports, among these dealers, an association between violent activity within the drug trade and violence and criminal activity outside of the drug business. "[I]t appears," he concluded, "that processes of self- and social selection result in the participation of generally violent and criminally active people in drug selling" (Fagan 1992).

The drug trade also contributes to crime by diverting inner-city youths away from legitimate pursuits of school and employment. Not only does the drug business introduce them to criminal enterprise, it also increases their risk of substance abuse,² and weakens their prospects for legitimate work (prison time makes for a bad résumé entry),³ all of which make it more likely that they will engage in criminal activity even outside of the drug business.

If the drug trade diverts individuals away from the above-ground economy, it also diverts the resources of the criminal justice system. This too may encourage crime. There are more than

² It has been widely reported by ethnographers that more and more young drug dealers are abstaining from use. However, a recent study that interviewed 121 male youths several months after their release from the Rikers Island Adolescent Reception and Detention Center in New York City casts some doubt on this theory. Although almost two-thirds of them denied *ever* having used cocaine, hair testing indicated that 71 percent of the respondents had used cocaine in the past 90 days (Magura et al. 1993).

³ Contrary to popular conception, many dealers sell drugs part-time, doing legitimate work as well (Reuter, MacCoun, and Murphy 1990). The work, however, tends to be sporadic and low-skilled.

a million drug arrests a year in the U.S.; without question, this imposes a tremendous burden on police, courts, and prisons. More than half of the residents of federal prisons are committed for drug offenses; in state prisons, the figure is roughly 30 percent (U.S. Department of Justice 1992). In a world of finite criminal justice resources, drug law enforcement reduces the risks of committing non-drug crimes and the number of non-drug offenders incapacitated (Blumstein 1993).

However, while shifting criminal justice resources towards drug offenses certainly reduces the deterrent to non-drug crime, not all of it reduces isolation benefits, because most of those who are prosecuted for drug crimes have very high rates of non-drug offending as well. Indeed, there is some evidence that, on average, those incarcerated for drug offenses and those incarcerated for other crimes have committed non-drug offenses with the same frequency (Cohen and Nagin 1993). So using a prison cell to house an arrested drug offender may buy, in incapacitation, as much reduction in non-drug crimes as would using that prison cell to house someone caught for a non-drug offense. In fact, if making drug arrests involves less police work than making non-drug arrests, it is possible that arresting and prosecuting individuals for drug offenses is an efficient approach to reducing non-drug crime.

Such a policy would still reduce the deterrence against predatory crime among all offenders and both the deterrence and isolation effects among non-drug dealing offenders, and for the significant minority of drug offenders with little or no other criminal activity (couriers, many low-level marijuana and hallucinogen dealers), the costs of arrest, prosecution, and imprisonment are deadweight losses from a crime-control perspective. In any case, very long sentences as provided by Federal drug laws and many state drug laws for a wide range of

offenses are likely to be crime-increasing for two independent reasons. First, the deterrent value of any given amount of punishment can be increased by spreading it more evenly across the class of those eligible to be punished, increasing certainty at the expense of severity (Cook 1981). Long sentences do the opposite. Second, the incapacitating effect of isolation depends on the "personal crime rates" of those incarcerated, and offending tends to diminish with age. The longer the sentence, the older the offender during its later years, and the fewer the offenses that are prevented by his (rarely her) incarceration. ("Three strikes and you're out" laws, which provide for life imprisonment without parole for repeat serious offenders, are especially subject to this objection.)

Economically-Motivated Crime Among Users

The proposition that drug abusers commit crimes to get money to buy drugs is straightforward enough. The desire for drugs among habitual users can be an extraordinarily powerful one, and for many heavy users of expensive drugs, crime is the only feasible source of the requisite funds. Once again, there is plenty of circumstantial evidence. Fred Goldman found that among heroin addicts, ninety cents of each criminally earned dollar was spent on heroin (Goldman 1976, 1977, 1981). In studying New York City heroin addicts, Bruce Johnson and his colleagues found a close match between criminal income and drug expenditures (Johnson et al. 1985; Johnson, Anderson, and Wish 1988).

Yet, like many conjectures about drugs-crime connections, the idea that users commit crime for drug money is hard to prove. What we know is that there is a clear association between heavy use of expensive drugs and income-generating crime, and that this relationship holds for

individual users, who commit more crime during periods of heavy use, and less crime during periods of lower use or abstinence (Chaiken and Chaiken 1990).

But there are other possible explanations for the observed relationship between drug use and crime. Drug use itself may induce anti-social behavior (including crime), and there may be other factors, such as indifference to risk and willingness to deviate from established norms, that cause both drug abuse and crime. (This is sometimes called the “criminal subculture” theory of drugs and crime). Lastly, there could be the paycheck effect: just as some heavy drinkers splurge at their local bar on payday, drug-involved offenders may buy drugs because crime gives them the money to do so. In other words, income-generating crime may cause drug use.

Despite this methodological difficulty, common sense leads us to believe that a non-trivial amount of crime among addicts is economically motivated. And many drug-involved offenders acknowledge this: according to a 1989 survey of convicted jail inmates, 39 percent of cocaine and crack users claimed to have committed their current offense to get money to buy drugs (U.S. Department of Justice 1991).

What can also be said, with more certainty, is that economic motivation is an incomplete theory of crime among heavy drug abusers. First, the survey of jail inmates just cited also implies that 61 percent of cocaine and crack users committed their current offense for reasons *other* than drug money. Second, there is a substantial body of research indicating that, while drug use does appear to intensify and perpetuate criminal behavior it usually does not initiate it (Ball, et al. 1981; Weisman, Marr, and Katsampes 1976). Most street drug users appear to have been involved in crime before drug use. (Anglin and Speckart 1986, 1988; Ball 1986; Ball et al. 1982; Ball, Shaffer, and Nurco 1983; Inciardi 1979, 1980; Inciardi, Horowitz, and Pottieger

1993; Inciardi and Pottieger 1991; Johnson et al. 1985; McBride and McCoy 1982; Nurco et al. 1985; Nurco, Kinlock, and Balter 1993; Stephens and McBride 1976). So while the need for drug money may be a motivating factor for some crime among criminally-active users, it did not, in most cases, cause them to become criminals. Third, most crime, even among drug addicts, appears to be opportunistic rather than planned, a complicating fact for a theory that assumes some level of economic rationality (Cook 1986). Fourth, as noted earlier, more crimes are committed under the influence of alcohol than under the influence of all illegal drugs combined. (U.S. Department of Justice 1988, 1991). Presumably, few of them are committed to get money to buy booze.

Making Sense of the Drugs-Crime Connections

It has become common for researchers to characterize drug-related crime according to a highly influential typology of drug-related violence advanced several years ago by P. J. Goldstein (Goldstein 1985). Goldstein offered three models: the psychopharmacologic, the economically compulsive, and the systemic. The psychopharmacologic model suggests that drug abuse will cause some individuals, either in the short run or long run, to be more prone to violent behavior. The economically compulsive model accounts for behavior that is economically motivated. The systemic model captures the violence intrinsic to the drug trade.

The framework, which is broadly similar to the categories we outlined above, is a good starting point for thinking about the drugs-crime connection, in part for what it clarifies, but also for what it obscures. The framework clarifies in this sense: if there is a drug-crime connection,

that is if the observed patterns of association are not merely spurious, then any causal relationships will be described, almost by definition, by one or more of the three models.

However, what seem to be mutually exclusive logical categories are less neat and clean when one attempts to identify them with empirical observations. The killing of one crack dealer by another in a business dispute appears “systemic,” but may in fact stem from the effects on both of them of their chronic cocaine abuse and their consequent irritability. In contrast, a killing with no obvious nexus to the illicit business—over jewelry or a pair of sneakers—may employ the weapons, and reflect the personal operating styles, acquired in the drug trade. Moreover, there are apt to be important contributory non-drug causes that are not captured at all by Goldstein’s framework. Perhaps the key factor is an inner-city culture that does not allow either party to a dispute to walk away peacefully while maintaining reputation and self-respect.

Another danger posed by such a framework is the tendency to over-generalize. Some scholars, for example, have pointed out the great variability in drug trade violence, noting that it is difficult to generalize across time and drug, and emphasizing the role of context-specific factors (Watters, Reinerman, and Fagan 1985). Ansley Hamid, for one, has argued that “the rate, type and volume of violence attaching to the use or distribution of any particular drug result from its unique impacts upon particular neighborhoods” (Hamid 1990, p. 32). Hamid stresses that much violence we are now witnessing in inner-city neighborhoods is peculiar to the particular circumstances surrounding the growth of crack. In addition to the economic and social deterioration of inner city communities, he points to aspects of the crack trade that are not typical for other illegal drug businesses—very young dealers, centralized retail distribution operations, curbside sales.

A final danger of any such framework is that it can highlight differences where, from a policy perspective, it may not matter. Consider the evidence that drug users commit more crime during periods of heavy addiction, less during periods of abstinence or reduced use. Is this because heavy drug use increases the economic motivation to commit crimes, or is the heightened criminal activity the product of the intoxicating and dehumanizing effects of some patterns of drug use? For certain policy decisions, the answer may be irrelevant. Either explanation implicitly endorses policies that reduce drug use, for a reduction in drug use will, other things being equal, reduce crime. For policy purposes, it is often sufficient to know whether depressing the brake or accelerator makes the car go slower or faster. Arguing about why can sometimes distract us from learning how to drive.

Differences Across Drugs

It is common to talk about illicit drugs as if they were a single substance. While this is convenient, it often obscures important differences. Illicit drugs vary in pharmacological effects, patterns of use, prices, and availability.

Surely, the nature of the connection between drugs and crime must vary across drugs. Of the three major illicit drugs of abuse (marijuana, cocaine, and heroin), one would expect marijuana to be the least implicated in crime. Marijuana habits are cheap compared to cocaine and heroin habits, and so there is probably much less economically motivated crime committed by its users. Marijuana dealing is comparatively discreet and therefore relatively peaceful, in part because marijuana users make fewer purchases than heroin or cocaine users. (Because they do not typically engage in the sort of binge use that stops only when their drug supply is

exhausted, marijuana smokers are able to buy in bulk and hold an inventory.) Finally, marijuana does not appear to generate much abuse-related crime. Those high on marijuana are not typically violent, and marijuana is less likely to bring its users into a criminal subculture. This reasoning is supported by the observation that although marijuana is the most widely used illicit drug, it shows up less often than cocaine in arrestee urine samples, and in many cities less frequently than opiates (National Institute of Justice 1993).

The differences between cocaine and heroin are less clear. Although there are some indications that heroin use is on the rise, active criminals are still much more often using cocaine or crack. Violence is more common in the cocaine business, but this may be change if, as some recent evidence suggests, cocaine organizations enter the heroin trade and retail dealers sell both drugs. Pharmacologically, cocaine addicts are more prone to aggression, and thus, presumably to violent crime. Criminally-active heavy cocaine and heroin users probably commit income-generating crime at roughly similar rates; in dollar terms, their drug habits appear comparable.⁴ However, chronic heroin users appear to be more persistent in their habits than chronic cocaine users, and if this translates into longer criminal careers, lifetime offending rates could be higher among heroin abusers.

DRUG ABUSE CONTROL POLICIES

In what follows, we survey a variety of drug abuse control policies, discussing their likely impacts on both drug abuse and crime. For purposes of taxonomy, policies are grouped into

⁴ According to an analysis of 1990 data from the Drug Use Forecasting Program (DUF), mean and median self-reported weekly expenditures on cocaine by heavy cocaine users were \$430 and \$217, respectively. Mean and median weekly expenditures on heroin by heavy heroin users were \$519 and \$216 (Rhodes et al. 1993).

three categories: legal status, law enforcement, and prevention and treatment. While these classifications parallel the custom of distinguishing drug policy strategies as either supply reduction or demand reduction, that distinction probably obscures more than it reveals.

The distinction is straightforward on the surface: drug consumption is a function of demand and supply, of individuals' desire to use drugs and the expense, difficulty, and risk of obtaining them. But the line between demand reduction and supply reduction policies is hard to draw. Typically, drug enforcement is considered supply reduction, while prevention and treatment are placed on the demand side. But suppose high drug prices, stemming from drug enforcement, convince an addict he can no longer support his habit, prompting him to enter a treatment program that reduces his appetite for drugs? And what if, relieved of the financial pressures of his addiction, the addict gives up dealing as well, thereby reducing the supply of drugs? Has enforcement become a demand-side policy and treatment a supply-side one?

Legal Status

The sale and possession of heroin and cocaine is a criminal offense everywhere in the U.S. Other substances—such as alcohol, tobacco, and pharmaceuticals—are not completely prohibited, but their purchase and sale is more or less regulated. In practice, the legal status of marijuana use often falls somewhere in between: although prohibited by Federal law, genuine possession arrests (simple possession rather than possession with intent to distribute) are rare, and in some states, possession of small amounts is a non-criminal offense.

There is no sharp line distinguishing prohibition from decriminalization or regulation; all limit the legal access to drugs. Morphine, PCP, codeine, and cocaine are all listed under

Schedule II of the Controlled Substances Act, yet we generally think of cocaine and PCP as prohibited, and codeine and morphine as regulated. Prohibition is nothing more than extremely tight regulation, and regulation is simply targeted prohibition.

Drug policy can use regulation to control a variety of behaviors connected to drug sales and use. Laws can regulate intoxicated behavior, such as driving while intoxicated (DWI) or public drunkenness. Laws can regulate commerce, placing restrictions on potency and form, commercial behavior, limiting the times, and places of sale. Beer and whiskey are only allowed to have a certain alcohol content; cigarettes cannot be advertised on television. There can be limits on the purpose of use, as we now have for prescription drugs. There can be restrictions on who uses, such as the prohibition for minors, although enforcing those restrictions is a different matter.

Prohibition is less discriminating in its approach. It threatens all sellers, buyers, and users, rather than some, with criminal penalties. It also expresses a collective sentiment that drug use is dangerous, if not wrong in itself (Moore 1991). Decriminalization tries to find a middle ground between regulation and prohibition. It threatens sellers as in a prohibitory regime, but by and large lets users alone. (This was the regime called Prohibition when applied to alcohol.)

In comparison to a legal, unregulated regime, the prohibition, decriminalization, or , regulation of drugs will reduce consumption, and thereby the crime that is attributable to the pharmacology of drug consumption. Legal status may also have an impact on user crime, apart from the effect on consumption. For instance, the fact that decriminalization does not brand apprehended users criminals may make them less prone to break other laws.

Regulation will usually result in a smaller black market than prohibition or decriminalization, although a well-enforced prohibition could easily have a smaller illicit market than poorly-enforced regulation. (Partly this is a matter of definition; more adolescents obtain alcohol than buy any illicit drug, but the alcohol supply system for juveniles does not involve professional illicit dealers.) Decriminalization will tend to result in the largest black market; there is no legal market, and buyers are not as strongly deterred as they would be by a prohibitory regime. Size matters: other things equal, a large black market for a given drug will tend to entail more black market-related crime than a tiny market for the same drug. But the marijuana market, with more customers than the heroin market (and comparable total expenditures), is much less violent.

Despite the vast territory of potential policy that lies between complete prohibition and virtually free legal commerce, drug policy is commonly framed as a matter of prohibition vs. legalization (Kleiman 1992b). This has a censoring effect on drug policy discourse; discussants are labeled and divided into warring camps, and middle ground policies that do not jibe with either the extremes of prohibition or legalization go unnoticed for that reason, or are summarily dismissed as being steps down the slippery slope to the enemy's position. Nonetheless, the legalization question is too prominent for us to ignore, and so we will comply with convention before turning to what seem to us more immediately pressing questions. To explore the crime-control issues at stake, and the range of possible effects, we consider in turn the legalization of three currently illicit drugs: marijuana, PCP, and cocaine.

Legalizing Marijuana

Making marijuana legally available to adults on more or less the same terms as alcohol would tend to reduce crime both by greatly shrinking the illicit market and by reducing alcohol consumption via substitution (since drinking seems to have a greater tendency to unleash aggression than does smoking pot). Insofar as some marijuana users are now committing income-producing crimes to pay for their habits, the price reduction which would follow legalization would also tend to decrease crime. In addition, if, as many studies suggest, marijuana is a “gateway” to other illicit drugs primarily because it is illicit (Clayton and Voss 1981), the legalization of marijuana, by breaking the link between marijuana users and illicit drug dealers, would be expected to somewhat reduce the number of cocaine and heroin users (substitution effects might work in the same direction). It is rather difficult to see any effects of marijuana legalization that would be crime-increasing, unless legalization for adults increased use by teenagers in ways that decreased either their prudence or their legitimate opportunities.

This does not strictly imply that marijuana legalization on the alcohol model would be, on balance, desirable. The almost inevitable increase in overall intoxication, and in the number of persons who become heavy, chronic marijuana users, would create offsetting non-crime costs. Either the current prohibition, or some legalization under much stricter controls on quantity and on intoxicated behavior than now apply to alcohol, might be the better course (Kleiman 1992b). But if crime control were the only social objective, marijuana prohibition, at least as it is currently implemented, could not stand.⁵

⁵ By the same token, very high cigarette taxes, or even the prohibition of tobacco, might be well justified for the protection of the public health, but either one would necessarily increase, rather than decrease, crime, since cheap, legal nicotine does not seem to be criminogenic.

Legalizing PCP

By contrast, the legalization of phencyclidine (PCP) would almost certainly increase crime. The illicit markets in PCP remain small, both in the number of users and in the revenues involved. (Revenues are small in part because the easily-synthesized PCP remains cheap even as a forbidden commodity.) Thus legalizing PCP would not eliminate much illicit-market crime, avoid much economic crime by users, or free much in the way of law enforcement resources. Even a small increase in crime related to intoxication and addiction would make PCP legalization a net crime-increaser.

It is quite possible that PCP does not fully deserve its evil reputation as the generator of bizarrely aggressive behavior; some of that effect surely relates to the sociology of its users rather than the pharmacology of the drug. Evidence for this is that ketamine, a closely-related product used by a much more sophisticated and less impoverished group of users, has no such reputation. It is also possible that other chemicals produced in the course of careless illicit synthesis and mixed with what is sold on the street as PCP are responsible for a considerable share of PCP-related crime.

Still, given that PCP today represents a tiny contributor to crime, legalizing it as a measure of crime control would be a far-fetched notion. Thus, marijuana and PCP form the two ends of spectrum of drugs in terms of the effects of legalization on crime rates.

Legalizing Cocaine

But of course the main event on the legalization fight-card is not marijuana or PCP, but cocaine. It is cocaine whose trafficking and consumption in the face of prohibition causes

enormous amounts of crime and causes a massive hemorrhage of enforcement resources. Would legalizing cocaine reduce crime?

No one knows. Even were the details of the “legalization” better-specified than they usually are by proponents or opponents, the effects of cocaine legalization would be so numerous, so profound, and so unpredictable that any strongly-expressed opinion on the subject must reflect some mix of insufficient intellectual humility and simple bluff. No one knows, and there is no plausible way of finding out, short of actually legalizing cocaine over a wide region for a long time. (Even then one couldn’t be sure, as other factors would be changing.) A survey of the likely effects of cocaine legalization will serve to justify this sweeping negative claim.

If cocaine were sufficiently legal so that the heavy users, who account for the vast bulk of illicit purchases, could instead obtain legal supplies—which would mean, in effect, selling unlimited quantities, as is now the case with alcohol—illicit cocaine dealers would be put out of business. In the short run, this might increase predatory crime, as some turned to theft as the next-best alternative to honest work in the absence of an illicit cocaine market, and others tried to muscle in to the remaining illicit drug markets (if any). Also in the short run, the supply of guns purchased for use in the cocaine trade and with its proceeds would remain in the hands of young men with short fuses.

In the long run, however, smaller illicit-market revenues would translate into less illicit-market crime, and the shrinking of the illicit business with the greatest attractiveness to young men with few marketable skills would tend to increase their job-market participation and decrease the proportion of them with prison records and expensive weapons. At the same time, about twenty percent of the nation’s law enforcement, prosecution, and corrections resources

would be freed up to deter and punish predatory crime instead of cocaine dealing. (It is possible, though not certain, the resulting reduction in the incarceration rate would tend to increase the stigma on incarceration and thus its deterrent value.) Thus the legalization of cocaine would have two large crime-decreasing effects, one via the crime associated with illicit markets and the other through relieving the strains on criminal justice institutions.

Whether cocaine legalization had a similar effect on the income-producing crime of cocaine users would depend on its details, and especially on the price set by taxation. Legalization near current black-market prices (about \$100 per gram) would presumably increase user crime, since there would be more users due to reduced stigma and enforcement risk and increased availability but no less need of money among those who did become heavy users. Moreover, some of the income needs of heavy users now satisfied by dealing would have to be satisfied by theft instead.

At prices closer to the free-market price (\$5 per gram, or about twenty-five cents per rock of crack), income-motivated crime by users would probably decrease; since habits would be much cheaper to finance, a smaller proportion of chronic users would resort to crime as a source of income, and it is doubtful that total spending on cocaine would go up (this would require a greater than 20-fold increase in cocaine use). But how about intoxicated crime, and the crime resulting from the long-term effects of addiction? Here legalization, even at high prices, is almost certainly worse than prohibition, and legalization at low prices substantially worse than that. Since cocaine (as opposed to coca leaf) has never been legal anywhere since the invention of cocaine-smoking, there is no compelling way to estimate the number of people who would try it if it were legal and cheap, or the proportion of them who would go on to, and persist in, habits

of very heavy use, or the proportion of heavy users who would become aggressive either under the immediate influence of the drug or due to its chronic effects. (Probably a smaller proportion than now do so, given the reduction of economic pressures, the elimination of the need to deal with black-market criminals, and the dilution of the cocaine addict pool by persons with less initial commitment to criminal lifestyles; but how much smaller is anyone's guess.)

Let anyone who doubts that the horrible cocaine/crime situation of today could get worse contemplate the alcohol/crime problem, and recall that alcohol plus cocaine is a frequent drug combination. Even without the nightmare fantasy of developing as many cocaine addicts as there now are alcoholics, cocaine legalization could greatly increase the level of cocaine abuse and the level of alcohol abuse, thus creating a double pharmacological source of crime increase to set off against the likely decreases in economic and systemic crime.

Given what a miserable experience heavy chronic cocaine use can be for the user and his or her intimates and neighbors, and given the near-certainty that any thoroughgoing legalization would increase substantially the number of persons going through that experience, we would think legalization justified only if there were a very strong balance of probabilities in favor of a noticeable crime decrease. Thus in this case our agnosticism in terms of its crime-control effects leaves us opposed to cocaine legalization as an overall proposition.

Law Enforcement

Traditionally, legal scholars drew a distinction between acts that were considered *mala in se*, or inherently evil, and those that were *mala prohibita*, not immoral in themselves, but merely proscribed by the laws of society (Blackstone 1890). The thinking is out of favor today; too

many sociologists and philosophers have pointed out that even definitions of murder differ greatly across societies (MacIntyre 1981). But the spirit of the idea lives on, and the common differentiation between “predatory” and “consensual” crimes—murder, theft, or robbery as opposed to prostitution, bookmaking, or drug trafficking—reflects in part a feeling that some behaviors are just plain wrong, while others simply have bad effects.

Moreover, the distinction is useful in thinking about drug enforcement. It reminds us that the purpose of such policy is not simply to catch and punish “bad guys.” Although retribution is an objective in enforcing any criminal law, drug enforcement is, or at least ought to be, principally an effort to influence the conditions of potential drug taking, such as the price and availability of drugs.

Raising Prices

One of the primary aims of current drug policy is to raise the prices of illicit drugs. The logic is that of elementary economics: purchases of heroin, cocaine, or marijuana, as of any commodity, are influenced by price. Other things being equal, one expects lower prices to be accompanied by greater use, and higher prices to go with less consumption.

A prohibitionist drug policy attempts to raise drug prices through the vigorous enforcement of laws prohibiting the sale and possession of drugs. Imprisoning traffickers and dealers, seizing their drugs, money, and physical assets—all of these actions impose costs on the drug trade, costs which are presumably passed on to consumers in the form of higher prices (Reuter and Kleiman 1986). A regulatory drug policy can raise price through taxation.

But any reduction in drug use that is obtained in this manner is purchased at a high cost. Where drugs are prohibited, higher drug prices brought about through enforcement can amplify black market violence. Enforcement shrinks the size of the drug trade (in terms of quantity sold, not necessarily revenues), but in the process makes the business more lucrative for those who survive. This increases the incentive for dealers to engage in violence and corruption to protect themselves and their livelihood. Where drugs are taxed, higher taxes may foster the creation or growth of a black market. Under either legal status, high prices can have another unwanted effect: users whose habits become very expensive to support, but who cannot or will not quit, may turn to theft, drug dealing, or prostitution as a source of income.

The key to the connection between drug prices and crime is the strength of the relationship between drug prices and consumption: what economists call the price-elasticity of demand. If consumption falls only slightly as prices rise (i.e., if demand is highly inelastic), then enforcement efforts that successfully drive up the price of drugs will have only a moderate impact on consumption, bringing only a slight reduction in those crimes attributable to drug abuse. Worse, if the percentage change in consumption is smaller than the percentage change in price (i.e., less than unit elasticity), total expenditures go up along with prices, and we would expect to see users committing more crimes for drug money. Higher prices and greater revenues would also be expected to increase drug-related violence. Even in this case, it is in principle possible that the fall in abuse-related crime would be greater than the combined increases in crime committed by dealers seeking competitive advantage and crime perpetrated by users looking for drug money, but the arithmetic of relatively inelastic demand is discouraging.

If, on the other hand, the demand for drugs is more than unit elastic, effective drug enforcement will have more positive consequences. Higher prices will cause a more-than-proportional drop in consumption, lowering total expenditures on drugs. This should cause a decline in crime connected to abuse and in crime motivated by economic need, and leave dealers with fewer illicit dollars to fight over (and potential dealers with fewer illicit opportunities to divert them from licit employment).

The price-elasticity of demand for a given drug is not an unchanging constant, like its molecular weight. It varies from user to user, and thus may rise and fall as the mix of users changes. It also varies with the price itself; other things equal, one would expect the price-elasticity of demand to rise with price, since the impact of, say, a 10 percent price increase on a user's budget will tend to be greater if the drug is already expensive. It varies as well with the availability and price of substitutes (in the economic sense of that term): other drugs, other recreations, and help in shedding unwanted drug habits.

Moreover, the short-run price elasticity—the effect of today's price change on today's consumption—is different from the long-run elasticity, which takes into account the effect of price change on consumers' habits and personal routines. In the case of gasoline during the two oil shocks of the 1970s, for example, the stock of automobiles and the distribution of commuting distances were both fixed. Over time, though, higher fuel prices led people to buy more efficient cars and to move closer to work. The long-run elasticity was near unity, though the short-run elasticity was only about 0.1 [cite].

Accurately estimating the elasticity of demand for a legal commodity is very difficult. There are countless factors other than price that influence demand, and distinguishing these—in

effect, holding non-price factors constant—is a methodological challenge. Estimating the elasticity of demand for illicit drugs is considerably harder. The usual problems are magnified by the lack of reliable data. If one were estimating the elasticity of demand for gasoline, for instance, one could easily find accurate figures on gasoline prices and consumption. But with illicit drugs, prices are not reliably or consistently measured, and quantity, since it is not an observable variable, must be indirectly estimated.

As a result, most of the research and discussion on the demand for illicit drugs has been speculative rather than empirical. Much of this work implicitly assumes that the demand for illicit drugs is almost perfectly inelastic. For instance, advocates of drug legalization commonly argue that higher prices do little to curtail use, and that the drastically lower prices that would prevail in a legal regime would not significantly increase consumption (Trebach in Trebach and Inciardi 1993).

This assumption is based partly on the model of “addiction” as involving a fixed daily “habit” not subject to the user’s choice, a model only vaguely applicable to heroin and almost completely irrelevant to cocaine, which tends much more to binge use. Even for those who are in fact heavy daily users and who struggle to maintain their habits to avoid withdrawal—the group whose elasticity of demand would seem at first blush to be lowest—demand will still be somewhat elastic if drug purchases make up a very large proportion of the user’s income. To assume that demand for addictive drugs is highly inelastic is also to ignore the effects of price on initiation, intensification, quitting, and relapse, the four processes by which the addict pool grows or shrinks.

Moreover, available evidence provides little support for the low-elasticity theory. Historically, sharp increases in heroin prices seem to bring about similarly sharp decreases in heroin-related overdoses (DuPont and Greene 1973; Boyum 1992). And higher cocaine prices are correlated with fewer cocaine-related emergency room episodes, fewer cocaine-related deaths, and a lower percentage of arrestees testing positive for recent cocaine use, while lower cocaine prices are correlated with the opposite effects (Hyatt and Rhodes 1992).

A number of studies have estimated, or reviewed estimates, of the elasticity of demand for alcohol and tobacco, which, of course, are also addictive drugs for some users (tobacco for most). Given the variety of methodological approaches employed, it is not surprising that the estimates vary widely. But most of the research suggests that the demand for alcoholic beverages and cigarettes is only moderately inelastic (elasticity of demand smaller in absolute value than, but close to, 1). The findings make it hard to credit the idea that illicit drug demand is very inelastic, particularly when one considers that illicit drugs are much more expensive than alcohol or cigarettes.

As far as empirical estimates of the elasticity of demand for illicit drugs goes, only two studies have been widely regarded as methodologically respectable. Both examined the link between heroin prices and crime in the early 1970s, and only indirectly looked at elasticity of demand (Brown and Silverman 1974; Silverman and Spruill 1977).

Brown and Silverman found, for New York City, a positive correlation between the price of heroin and rates of different types of crime. Significantly, the association was generally stronger for the revenue-raising crimes (such as robbery, burglary, and auto theft) that addicts would commit to finance drug purchases than it was for violent crimes.

Data for the other eight cities examined did not provide much support for the New York City findings. Some cities (e.g., Houston) revealed a positive relationship between drug prices and crime, while other cities (e.g., Boston) showed a significant negative relationship. In other cities (Chicago, Detroit, Miami), results were mixed.

Silverman and Spruill performed a similar, but more detailed, analysis for Detroit alone. The data showed a strong association between heroin prices and crime, especially for property crimes. Overall, Silverman and Spruill estimated that a 50 percent increase in the price of heroin would result in a 14 percent increase in total property crime.

Several important points are raised by these two widely-cited studies. First, that the association between drug prices and crime was positive in some cities, negative in others, and unclear in most, underscores that a variety of factors other than drug prices affect crime levels, and that some of these factors may affect the relationship between drug prices and crime.

Particularly important in this regard may be the availability of treatment. In a careful study of heroin use in Washington, D.C. in the early 1970s, Robert DuPont and Mark Greene found that heroin use declined in conjunction with a rise in heroin prices and a fall in reported crimes (DuPont and Greene 1973). Their analysis suggests that the crime rate fell because of a decline in heroin addiction, just as the crime rate had increased over the previous decade due to a growth in addiction. A sharp increase in heroin prices, the result of vigorous law enforcement efforts, was instrumental in reducing heroin use, but only, in their view, because treatment was made available. In effect, DuPont and Greene argue that the association between heroin prices and crime is negative when treatment is available, positive when it is not.

Moreover, studies like Brown and Silverman's or Silverman and Spruill's can only measure the elasticity of demand in the short run. Thus their estimates are likely to understate the effect of price changes once users have the opportunity to discover and habituate themselves to substitute drugs, enter and complete treatment programs, and so on.

For the purposes of drug policy, we are primarily interested in the long run elasticity of demand, because the size of the user population over time is a function of long run initiation and quit rates. It is quite possible that the demand for illicit drugs is inelastic in the short run and elastic in the long run. In the short run, demand is above all a function of consumption among current addicts. Their demand is unlikely to respond quickly to a price increase; not only is it difficult for them to immediately adjust their habits, but they know that most jumps in illicit drug prices reflect temporary interruptions in supply rather than lasting trends. If the higher price persists, thereby maintaining and giving credibility to the economic pressure, it becomes more worthwhile for them to invest in changing their habits.

At the same time, the higher price reduces both initiations and progressions from initiation or moderate use to heavy use (Moore 1990). In principle, the addictive nature of drugs may contribute to these effects. A rational person considering whether or not to take an addictive drug should be more strongly influenced by a change in its price than he would be if the drug were not addictive, because the effect of the drug's price on his lifetime budget is greater (Becker, Grossman, and Murphy 1991). The evidence from cigarettes, however, suggests that most new users of even of highly addictive substances do not expect to become "hooked" [cite].

Over time, these changes in initiation and quit rates, even if small, can significantly alter the size of the user population. And if the demand for drugs is more elastic in the long run than

in the short run, we should expect time horizon to affect the connection between drug prices and crime. Specifically, it is conceivable that higher drug prices increase crime in the short run, as current users commit more offenses to finance their now costlier habits and dealers fight over a market with larger revenues, but decrease crime in the long run, as the user population shrinks and the illicit market shrinks with it.

The price of one drug may also influence the consumption of another, either positively or negatively, and this relationship may hold either at a moment or over time. Insofar as two drugs compete for users' time and money, as rival brands of beer do, a price rise for one will increase consumption of the other (substitution). If they are used together, as various depressants such as alcohol, heroin, and minor tranquilizers are with cocaine, then raising the price of one will tend to decrease the consumption of the other (complementarity). A special kind of complementarity, acting over time and only in one direction, involves situations where consumption of one drug increases the probability of trying another (which might be true, for example, of tobacco and other smoked drugs, or alcohol and other intoxicants, or marijuana and other illicit drugs). This unidirectional complementarity over time is known in the drug literature as the "gateway effect"; its existence remains highly contested (Clayton and Voss 1981).

The frequency of polydrug consumption among many heavy users suggests that both substitution and complementarity are likely to be important effects, but estimating them presents great methodological challenges. There is, however, some empirical evidence of interdrug substitution. John DiNardo found that raising the legal drinking age appears to increase marijuana use (DiNardo 1991). Comparing states that decriminalized marijuana in the 1970s with those that did not, Karyn Model has found that marijuana decriminalization tends to

increase the frequency of marijuana-related visits to hospital emergency rooms, but to decrease the frequency of emergency-room incidents involving other drugs, and decrease the homicide rate (which may reflect substitution of marijuana for alcohol) (Model 1991, 1994).

To the extent that drugs are substitutes, drug policy should concern itself with the relative, and not just the absolute, prices of illicit drugs. In particular, we would want to make sure that the prices of the most harmful and addictive drugs (heroin and cocaine) are very high vis-à-vis the prices of the less dangerous ones (marijuana) (Moore 1979). Failure on this score could be quite damaging. According to one researcher who has conducted focus groups with heroin users, many current heroin addicts claim to have turned to heroin in the late 1970s when marijuana supplies dried up (Rocheleau 1994).

That drugs can be substitutes and complements further complicates the analysis of drug prices and crime. It implies that one cannot consider the impact of a change in the price of one drug without considering the effects on consumption of other drugs. Without substitutability or complementarity, an increase in the price of marijuana would have a negligible impact on crime. As noted above, a marijuana habit is not terribly expensive to support, marijuana dealers rarely shoot each other in turf battles, and marijuana users are not typically violent or criminal. However, with cross-price effects, an increase in the price of marijuana could materially influence crime. Users might switch to, or increase their consumption of, cocaine, heroin, or alcohol, which would tend to increase crime. At the same time, reduced marijuana use might mean fewer initiations to cocaine and heroin.⁶

⁶ Model's finding (Model 1994) that lower legal barriers to marijuana consumption tend to decrease homicide, though important on its own terms, does not fully answer the substitute/complement question. It is possible, for example, that marijuana is a substitute for alcohol, but a "gateway" for cocaine and heroin, and that in terms of homicides, the alcohol connection is far more significant than the cocaine or heroin connection. A

Overall, we simply do not know whether, on balance, higher drug prices increase or decrease crime. By driving up prices, drug enforcement curtails drug consumption and the crime that is attributable to drug abuse. But higher prices may also increase crime committed by users to obtain drug money as well as violence among dealers. The net effect is uncertain. Furthermore, there is no reason to assume that there is a consistent relationship between drug prices and crime. More likely, the connection is context-specific, different for different drugs, cities, time periods, and price levels.

Mark Moore has pointed out that ideally we would like to have two completely separate drug markets (see Wilson 1985, p. 220). In one market, which would be open only to confirmed addicts, drugs would be sold at low prices, thereby reducing the need for addicts to commit crimes. In the second market, drugs would be expensive, thus deterring the initiation of new users. In practice, maintaining such an arrangement is difficult, as the history of British efforts to allow addicts legal access to drugs attests (Turner 1991); non-addicts have an incentive to achieve addict status, and arbitrage frustrates efforts to prop up prices in the high-price market.

There is one drug for which higher prices would clearly be crime-decreasing: alcohol. According to surveys of jail and state prison inmates, more crimes, and especially violent crimes, are committed under the influence of alcohol than under the influence of all illicit drugs combined (U.S. Department of Justice 1988, 1991). Arguably, alcohol-related crime represents the single largest external cost of substance abuse.

reduction in alcohol use might also explain Model's observed reduction in emergency room visits involving cocaine, since a large proportion of cocaine "mentions" involve alcohol as well.

A number of policy actions could reduce alcohol-related crime. Increasing taxes on alcohol is the most obvious. Alcohol consumption is responsive to price, and at present, the federal and state tax burden on the average drink is only about ten cents, roughly one-tenth its total price. Both economic efficiency and fairness dictate that alcohol taxes should be high enough to cover the costs that drinkers impose on others. They are not even close; even studies that exclude the costs of alcohol-related crime suggest that drinkers pay for only a third of their external costs (Manning et al. 1989). A good case can thus be made for alcohol taxes at the level of a dollar per drink (Kleiman 1992a). The effect on alcohol-related crime (including domestic violence and child abuse) would likely be substantial.

Of course, such a tax would have disadvantages. Trafficking and consumption of “moonshine” and other illegal alcohol products would increase, bringing with it damage from black market crime and adulterated drinks. But evidence from those foreign countries where alcohol is taxed more highly than in the U.S.—and from the early 1950s, when U.S. alcohol taxes were, in purchasing-power terms, several times higher than they are now—suggests that these effects would present only minor problems. It appears that the safety and convenience of legal alcohol, and loyalty to legal brands, are tough to compete with.

Restricting Availability

A number of years ago, Mark Moore pointed out that the demand for an illicit drug is not simply a function of its cash price, but rather its “effective price,” a measure that includes, in addition to its dollar price, toxicity of adulterants, access time, and risks of victimization and

arrest (Moore 1973). These non-monetary elements of the effective price can be thought of as the drug's "availability" to its users (Rocheleau and Kleiman 1993).

Three observations make the distinction between price and availability important. First, there is not a perfect correlation between price and availability; some kinds of enforcement actions affect price more than availability, while others affect availability more than price. Second, reductions in availability (i.e., increases in the non-money price) will not have the same unwanted side effects as an increase in price. Third, the non-money price is likely to be much higher for new drug users than for experienced ones. (Note that where drugs are not prohibited, regulation can be used to reduce availability. With alcohol, for example, states determine not only who is allowed to sell—by requiring licenses—but also what, where, and when.)

In principle, if enforcement could decrease the availability of a drug without increasing the dollar price, we would get the benefits of a price rise in the form of reduced consumption without its costs in increased expenditures and illicit revenues. In practice, enforcement cannot choose its effects so neatly and cleanly, but some types of enforcement do a better job of decreasing availability than others. The important distinction is between high-level and street-level enforcement. High-level enforcement (including interdiction and source country eradication efforts) boosts the dollar price of drugs, but has little impact on availability, other than by shrinking the overall size of the market. In contrast, street-level enforcement can directly affect availability. By threatening retail sellers, street-level enforcement can shrink their numbers, restrict their locations, and generally make them more cautious. Street-level enforcement also scares buyers. All of this should increase the non-money price of drugs, and there is some evidence that concentrated street-level enforcement, especially against relatively

small markets, can increase treatment admissions among users and decrease crime rates (Kleiman et al. 1988).

By making it more difficult and risky for retail buyers and sellers to complete transactions, street-level enforcement reduces drug consumption with fewer side effects than would accompany a policy that simply raised drug prices. A more crucial advantage of street-level enforcement is that retail drug markets are responsible for much of the violence and declining quality of life in inner-city communities. Insofar as it can scale back the volume and flagrancy of the retail drug trade, and in turn the violence that goes with it, effective street-level enforcement might help reclaim for law-abiding citizens large areas of their neighborhoods.

In practice, the results of intensive retail drug enforcement efforts are mixed, and evidence of a general relationship between the overall level of retail enforcement and the overall crime rate is lacking. Lynn, Massachusetts and Tampa, Florida are success stories, but failures are far greater in number (Kleiman et al. 1988; Kennedy 1993). Still, the victories have provided not only hope, but some important lessons about the components of a successful strategy.

What appears to be key is a shift away from the traditional approach of simply seizing drugs and arresting dealers towards a comprehensive and integrated strategy of market disruption (Kennedy 1993). The basic game plan of such a disruption scheme is to coordinate active community involvement with the resources of multiple government agencies in order to assault the drug market with a barrage of measures, which together make it so difficult for the market to operate that it virtually collapses.

Tampa's much heralded QUAD program was something of a model operation in this regard. With targeted enforcement, the police pressured sellers to continually change their

venues, and scared away buyers by seizing their cars in "reverse stings" where the police posed as dealers. Citizen information was used to identify and seize drug stashes. With the cooperation of other city authorities, abandoned houses were razed, bars and small stores implicated in drug dealing were closed down, and local ordinances were employed to clear crowds from known trafficking sites. Where six months of conventional enforcement had failed to curtail street trafficking, six months of the QUAD program virtually eliminated public drug dealing, bringing considerable reductions in violence, disorder, and fear (Kennedy 1993).

The usefulness of retail-level drug law enforcement as a crime control measure is likely to depend strongly on how large and widespread the retail market is for the drug under consideration and whether there is a risk that the number of users of the drug is about to rise substantially. A crackdown on a small market is both more likely to succeed and less expensive in enforcement resources. If sales are widespread, cracking down in one area may only have limited benefits. Retail enforcement is likely to be especially valuable for a drug for which initiations are rising, or seem poised to rise, because the increase in the non-money costs of drug acquisition weigh particularly heavily on new users.

Thus enforcement against retail-level cocaine dealing was a much more attractive program in 1985 than it is today; the market was smaller, but the number of actual and potential new users was larger. With heroin prices very low, but retail availability still quite spotty, retail heroin enforcement, especially in cities where heroin dealing is not yet widespread, may be a good investment of police resources today.

Sanctions for Intoxication

Much of the social damage caused by drug users occurs while they are intoxicated. As noted earlier, a majority of jail and state prison inmates report that they were intoxicated when they committed their current offense. Even allowing for the possibility that intoxication contributes to the likelihood of arrest, it seems that something like half of all crimes are committed under the influence of drugs or alcohol.

Presumably, some of these crimes would not have been perpetrated in the absence of intoxication, in large part because being drunk or high clouds judgment and diminishes self-control. In other words, for some individuals, in certain circumstances, the threat of punishment is a sufficient deterrent to crime when they are sober, but inadequate when they are intoxicated.

One approach to combating intoxication-generated crime is to discourage intoxication in the first place, or at least intoxication in settings where damaging behavior is particularly likely. Such a policy can take one of three forms: the law can proscribe intoxication *per se*, as do laws against drunkenness; or it can cast its net more narrowly, either with respect to persons—forbidding intoxication only to those who have committed crimes under the influence—or conduct—forbidding only dangerous or harmful intoxicated behavior. In practice, the last approach could involve two steps: first, punishing intoxicated individuals who are engaged in activities (such as driving) where their intoxication significantly increases risks to others; second, treating intoxication as an aggravating, rather than a mitigating, factor in punishing crimes (either in sentencing or crime definition). However, such policies raise difficult philosophical questions, and retributive considerations probably argue against some of them.

It is not difficult to justify laws against intoxication, at least intoxication in public. Becoming drunk or otherwise high is (for most people) voluntary behavior, and insofar as the risks it imposes on others are substantial, it amounts to reckless endangerment. But in only a small percentage of cases does intoxication lead to criminal or other anti-social acts, and it is hard to imagine severe punishments for intoxication, especially drunkenness. And if the penalties are light (on the order of a speeding ticket), they would provide little additional deterrent to the punishment for crimes.

Making intoxication an aggravating circumstance in crime commission is more problematic. Deterrence theory supports the idea: if intoxication weakens self-command, then logically it requires the threat of a greater punishment to deter someone who is drunk or high than to deter someone who is sober. However, is it really more blameworthy to commit a crime in a semi-conscious drunken stupor than when stone-cold sober? If anything, notions of culpability are more consistent with intoxication being a mitigation, rather than an aggravation of responsibility; the criminal law recognizes diminished capacity, and intoxication can contribute to behavior we would consider unrepresentative of a person's character.⁷

There are probably variations on these policies that are more palatable to our sense of justice. For instance, the law could proscribe, and punish with some severity, reckless intoxication, rather than intoxication *per se*. Implicit in such an approach is the notion that intoxication increases the likelihood of socially irresponsible or criminal behavior, and so those

⁷ As a matter of law, most U.S. jurisdictions do not allow a "diminished capacity" defense for voluntary intoxication. As a practical matter, prosecutors, judges, and juries often see the issue differently.

who get intoxicated have a duty to do so in a setting that minimizes these risks. Being armed while intoxicated, for example, could reasonably be forbidden.

Another avenue is to target only those previously convicted of offenses committed while intoxicated. In this way, the law would acknowledge both that not all individuals are crime-prone while intoxicated and that intoxication or intoxicated behavior is not always characteristic of an individual. With multiple offenses, the "I wasn't myself" defense is no longer convincing. Interestingly, John Stuart Mill advocated such a policy:

Drunkenness, for example, in ordinary cases, is not a fit subject for legislative interference; but I should deem it perfectly legitimate that a person, who had once been convicted of any act of violence to others under the influence of drink, should be placed under a special legal restriction, personal to himself; that if he were afterwards found drunk, he should be liable to a penalty, and that if when in that state he committed another offense, the punishment to which he would be liable for that other offense should be increased in severity (Mill 1989, p. 98).

However, while Mill's proposal to forbid intoxication to those convicted of intoxicated offenses is unexceptionable, the suggestion for enhanced penalties seems dubious on retributive grounds. Given that intoxication weakens judgment and self-control, it is hard to argue that committing a crime when drunk is worse than committing the same crime when sober, even when the perpetrator has a checkered past. Ultimately, any policy that treats intoxication as an aggravation has to be justified on the grounds that its deterrent value outweighs the violation of retributive principles. Given that a majority of violent crimes, including perhaps two-thirds of homicides, are committed under the influence of drugs and alcohol, such a claim deserves consideration.

There is also a practical problem with Mill's proposal. In effect, it tells problem drinkers that they can drink, but not get drunk, a bad strategy according to most substance abuse

counselors. Perhaps it is better to require those with a history of drinking problems (such as committing a crime while drunk) to follow a course of abstinence. Since enforcing such individual prohibitions would be difficult without the assistance of retail alcohol sellers, such an approach would seem to require some form of personal drinking licenses that could be revoked for intoxicated misbehavior (Kleiman 1992a).

Sentencing Policy

Not all drug offenders inflict the same level of damage on society. Indeed, research suggests that a small number of them represent society's most active and vicious criminals, and that they account for the lion's share of the violent and property crime perpetrated by drug offenders. These individuals ought to be a particular focus of criminal justice efforts.

An especially important step would be to use prison space more efficiently. Given limited prison capacity, it makes sense to give priority to housing the most active and violent offenders. Current federal policy is perhaps the most prominent example of the wrong approach. Under the law, relatively minor participants in drug trafficking, some with no prior arrests, frequently face long mandatory prison terms. According to a recent Department of Justice analysis, 21 percent of all federal prisoners are "low-level drug law violators" with no record of violence or incarceration. Of these, 42 percent are drug couriers (or "mules"), rather than dealers or principals in trafficking organizations [cite Heymann report]. Since those cells could instead be holding more dangerous offenders, the result of long mandatory sentences for minor drug offenders is to increase crime. Even if long sentences were given to offenders worth locking up, deterrence theory suggests that they would not be the best way to employ limited cell capacity to

deter drug dealing: certainty (maximized by handing out many shorter sentences) is more important than severity (Cook 1981).

Prevention and Treatment

The demand for drugs can be reduced in two ways: by altering the subjective states of users and potential users (attitudes, opinions, and preferences), or by changing the objective conditions of drug use to make it less pleasant or more hazardous. Even if attitudes were systematically harder to influence than objective conditions, there are at least two reasons why attitudes might nonetheless be the object of policy intervention, either through prevention or treatment programs. First, given the constraints of the justice system, supply reduction strategies have only limited capacity to raise the prices or reduce the availability of mass-market drugs. Second, in a liberal society, it is generally preferable that citizens behave responsibly, and obey the laws, for reasons of internal, rather than external, motivation. It is better, for instance, if our fellow citizens refrain from mugging us because they believe mugging is wrong, and not because they are afraid of getting caught. (It does, of course, matter how attitudes or values are internalized. Big Brother-like tactics might be useful in preventing drug abuse, but at substantial cost to civic and republican values. In the view of many, even some of the current anti-drug messages tread rather close to the line, both as to their freedom with the facts and their approach to prejudice and fear [cite].)

There are several ways in which changes in attitudes can influence drug abuse and its consequences. First, attitudes can reduce initiation, either because potential users believe drug use to be wrong or dangerous, or because drug use is stigmatized. (A worry here is that the same

attitudinal changes that reduce initiation may increase the rates of progression to heavy use, and of misbehavior, among those who do initiate.)

Second, attitudes can affect the progression to habitual use, or influence, the time, place, and character of intoxicated behavior. An obvious helpful example is the practice of choosing a "designated driver." A less obvious illustration is the Japanese perspective that intoxication is something to be flaunted rather than concealed, as is typical in Western societies. By being public about their drunkenness, the Japanese make it easier for those who are intoxicated to acknowledge their incapacities and for those who are sober to identify them.

Third, attitudes can influence the frequency and duration of cessation. Attitudes about addiction, attitudes towards ex-addicts, and beliefs about the probability and difficulty of successful cessation all matter.

Lastly, attitudes can influence involvement in drug dealing, which in turn impacts drug use and its consequences. When potential dealers enter the drug trade, they increase the availability and lower the price of drugs. They also tend to increase drug use and crime, since most of them eventually become users themselves.

Prevention

Prevention programs are an effort to change attitudes about drug use. From a policy perspective, successful prevention programs are a clear winner; they offer the benefit of reduced drug use without the baggage of black market side effects. That's the good news. The bad news is that few prevention programs have demonstrated that they can consistently reduce the number of their subjects who use drugs. And the positive results that have accompanied some programs

have often proved difficult to replicate in other settings. Added to this are concerns about some of the methods employed; many prevention instructors and some anti-drug advertising disseminate or broadcast demonstrably false information about the physical and psychological effects of drug use [cite]. The programs would have to be marvelously effective to justify this kind of misinformation.

Despite these difficulties, prevention programs deserve continued research and evaluation. Their focus should also be broadened to include prevention of drug dealing, especially given the growing evidence that dealing is less disapproved-of than drug drug-taking among inner-city adolescents. On average, it is much more valuable to convince a youth not to sell drugs than to convince him not to try them. Many youths lead successful lives despite having experimented with, or occasionally used, drugs. Fewer, especially in inner-city neighborhoods, prosper when they have sold drugs.

How to best prevent dealing is unclear, but since kids are clearly attracted by the promise of money, efforts would probably include an anti-conspicuous consumption campaign. This could involve, among other steps, uniforms and dress codes in schools to curtail the visible competition in expensive clothing, footwear, and jewelry. An anti-dealing strategy might also develop community alternatives to "hanging out," such as after-school or late-night recreational programs. Somewhat surprisingly, "midnight basketball" leagues have been shown to noticeably reduce the rates of some crimes where they have been tried.

While a discussion of education, social welfare, and economic policy is beyond the scope of this chapter, it is also important to note that the appeal of drug dealing or use depends partly on the alternatives. To the extent that there are better employment or educational or recreational

opportunities, we should expect less involvement in drug use and dealing. Drug prohibition may have important effects here, since a criminal record depreciates one's value in the job market. While this risk may keep some from using or selling drugs, it makes things more difficult for those who are not deterred. This cost needs to be weighed against the limited benefits of routine retail-level drug enforcement in cities with large-scale (as opposed to nascent) drug markets.

Drug Abuse Treatment

From a crime-control perspective, successful treatment of drug-involved offenders is another unequivocal winner. The criminal activity of addict-offenders seems to rise and fall in step with their drug consumption, and importantly, the relationship holds whether reductions in drug use are unassisted or the product of formalized treatment (Anglin and Speckart 1986; Nurco et al. 1988). Moreover, a treatment-induced reduction in demand does not bring with it the side effects of an enforcement-induced reduction (higher drug prices, depletion of criminal justice resources). Lastly, many drug-involved offenders sell drugs in addition to using them, and some may exit the drug trade if they gain control over their own habits.

Discussion of drug treatment seems to be dominated by two issues: whether or not treatment "works," and what can be done to increase the availability of treatment. Treatment advocates insist that drug treatment is effective and often call for "treatment on demand." Skeptics counter that abstinence is short-lived for the vast majority of treatment clients, and argue that a significant expansion in treatment services would, in effect, throw good money after bad. In fact, treating drug-involved offenders clearly has benefits in excess of its costs, but merely offering more treatment may not be the best approach to getting more offenders treated.

Evaluation studies indicate that all the major drug treatment modalities—therapeutic communities, methadone maintenance, outpatient drug-free programs—are modestly successful, at least according to most outcome criteria (Anglin and Hser 1990; Gerstein and Harwood 1990). The usual yardsticks are *post-treatment* levels of drug and alcohol use (rates of abstinence and relapse), and employment activity. While these measures may be sufficient for evaluating treatment for a stockbroker, they overlook what is perhaps the most important benefit of treating drug-involved offenders.

Findings from the Treatment Outcome Prospective Study (TOPS), to date the most comprehensive evaluation study of treatment effectiveness, indicate that the largest reductions in criminal activity, by a wide margin, occur *during* treatment. Among TOPS subjects treated three months or longer, about 60 percent of residential clients, and about one-third of outpatient methadone and outpatient drug-free clients, reported criminal activity in the year prior to entering treatment. Yet fewer than 10 percent of the clients in outpatient methadone and outpatient drug-free programs, and only 3.1 percent of residential clients, reported committing predatory crimes during treatment. In fact, this reduction in criminal activity is so large, that on cost-benefit grounds it would probably justify the treatment costs, even if treatment had no effect on post-treatment behavior (Hubbard et al. 1989).

Two points are often missed in discussions of treatment availability. First, many drug-involved offenders will only enter treatment if coerced; simple availability is often not a sufficient enticement. Second, drug enforcement and the criminal justice system are the most powerful mechanisms for getting drug-involved offenders into treatment; high effective prices

can convince users that maintaining their habits is too costly, and courts can offer or compel treatment as a condition of parole or probation.

For maximum crime control, treatment resources should be aimed at drug-involved offenders. Arguing against this approach is the fact that criminally-active drug users are often poor candidates for treatment, at least as evaluated by treatment providers who often have their eyes fixed on long-term abstinence as the target outcome. And indeed, despite having a captive clientele, most prison-based drug treatment programs have not been shown to reduce recidivism rates (Gerstein and Harwood 1990).

However, a small number of prison therapeutic communities (TCs), with strong linkages to community based treatment programs—such as the Stay'n Out program in New York—appear to work. An equally important research finding is that those who are coerced into non-prison treatment by the criminal justice system fare as well as, if not better than, those who enter such programs voluntarily (Anglin and Hser 1990). Together, these findings argue for more prison-based TCs (of course modeled on the better programs), and an expansion in the legally coerced treatment for non-incarcerated criminal-justice system identified users. (The former is actually relatively inexpensive, since housing, which is a major cost of TCs, is already paid for.

Typically, an in-prison TC adds only a few thousand dollars to the annual cost of prison alone.)

Evaluations of treatment programs indicate that monitoring of drug use by urine testing enhances outcomes. This raises the interesting question of whether carefully implemented programs of coerced abstinence—regular urinalyses combined with swift and sure sanctions for dirty or missed tests—could achieve some of the benefits of treatment at a much lower cost (BOTEC Analysis Corporation 1990).

Coerced Abstinence

Casual users account for no more than one-quarter of the total volume of cocaine consumed in the United States, and an even smaller fraction of the volume of heroin consumed. This is not because heavy users are very numerous; on the contrary. The total number of active heavy cocaine users and heavy heroin users in the United States probably comes to no more than three million persons, of whom about three-quarters derive a substantial share of their income from criminal activity (Rhodes, Scheiman, and Carlson 1993). These criminally-active heavy users are the main contributors to crime related to illicit drugs, both through their own criminal activity and through their contribution to illicit-market demand.

Since the sort of crimes committed to support heroin and cocaine habits are likely to result in fairly frequent arrest and conviction, a significant number of cocaine- and heroin-involved offenders are under the jurisdiction of the criminal justice system at any given moment, most of them on probation or parole. Their identification as offenders already being made, their identification as heavy drug users requires nothing more than a chemical test of urine or hair, and whether they continue to use is similarly straightforward to determine.

Given the very high personal crime rates characteristic of drug-involved offenders who remain heavily drug-involved, the substantial cost of imprisonment might not be too high a price to pay to avoid the crimes they commit while free, even putting aside the crimes committed by the drug traffickers they support (Cavanagh and Kleiman 1990). From the crime-control perspective, this would certainly be a better use of the cells than long sentences for minor drug dealers, who are certain to be replaced within the illicit labor market.

But it may not be necessary to imprison drug-involved offenders to reduce their drug consumption. The threat of incarceration for continued drug use might be adequate to deter many of them. The question is simply whether someone whose continued liberty is in principle conditional on obeying certain rules can, in practice, be effectively deterred from continuing to take illicit drugs and committing crimes to buy them.

The two keys to deterrence, especially for persons with short planning horizons and poor judgment concerning risk—two characteristics both likely to produce, and likely to be produced by, addiction to expensive illicit drugs—are certainty and swiftness. Severity is of less importance. The observation that quitting any drug habit involves repeated attempts and repeated failures only increases the importance of creating predictable but not catastrophic penalties for the failures that are almost certain to occur (and, ideally, rewards for periods of success).

Unfortunately, the current drug-testing practices of probation and parole departments do not pay attention either to what is known about deterrence or to what is known about recovery from addiction. Infrequent testing, and even more infrequent sanctioning for missed or “dirty” tests, are combined with unnecessary severity. Several months in prison is not an uncommon sanction for a “technical violation” involving drugs—in California, the single most common reason for a prison admission is a failed drug test—and sanctions of years are not unknown. Few better ways could be devised of absorbing large amounts of scarce punishment capacity with the minimum benefit in terms of deterrence or relapse management.

The alternative would be frequent (say, twice-weekly) tests and automatic, but mild, sanctions: perhaps two days’ confinement for the first failure, escalating with repeated failures

over a short period. Such a system has been proposed [DuPont, "Operation Tripwire"] and employed with some apparent success in various pilot programs [Rudolph and Kleiman], but never made routine in a large jurisdiction, or even carefully tested with experimental controls.

One reason for the failure of coerced abstinence to gain even a serious test is that it does not engage the professional interests of drug treatment providers, drug enforcement agents and prosecutors, or corrections officials. Another reason is that the proposal does not fit comfortably within the categories (supply vs. demand, tough vs. soft) that dominate the drug policy debate.

But if such a program could be made to work at large scale, the results might be dramatic: a reduction in total cocaine volume of 40 percent, far exceeding the impact of any other plausible program, would not be out of range. This would shrink not only the crime rates of those tested, but the illicit markets they prop up, and thus both dealing-related violence and the pull illicit markets exercise over poor adolescents. The cost, which has been estimated at about \$2500 per participant per year or about \$5 billion for a complete national program, would be at least partly offset by reduced imprisonment rates for the participants and for the cocaine and heroin dealers driven from the shrunken illicit markets. The availability of formal treatment would almost certainly decrease the violation rate among participants, but might not be essential to the program's functioning.

SUMMARY OF POLICY IMPLICATIONS

Because so much crime appears connected to the sale and chronic use of drugs, and because crime is widely thought the most serious of the harms associated with drug abuse, many Americans consider drug policy to be a massive crime prevention program. This view, which

does not see any trade-offs between reducing drug abuse and reducing crime, is analytically unsound. Any drug policy that includes efforts to limit or hinder access to drugs will generate, along with its benefits, unwanted side-effects. Specifically, such policy will decrease some types of crime, while increasing other sorts; in principle, the net effect can go either way.

Moreover, there is no reason to assume a consistent relationship between particular drug policy strategies and crime. More likely, policy effects are highly sensitive to the specific circumstances of implementation, and vary across drugs, cities, and time periods. To take one example: enforcement that results in increased heroin prices might lead to lower crime in cities where methadone maintenance is readily available, and higher crime where methadone programs are scarce.

Given such uncertainties, we are agnostic on some of the most hotly-debated issues of drug policy, such as whether legalizing cocaine in some form would reduce crime. At the end of the day, what can be said with any colorable show of confidence can be briefly said:

- Reducing the incidence of drunkenness will reduce crime, unless the control measures create a substantial illicit market. Increased taxation (up to some multiple of current rates) and a campaign of persuasion to make drunkenness less fashionable both seem like good candidates. Denying access to alcohol to those who have committed crimes under the influence would be harder to achieve, but the potential rewards would be large.
- Reducing the volume of cocaine consumed without raising its price will also reduce crime. Making treatment more available to non-incarcerated offenders is one way to do so.

- Very long sentences for minor, non-violent drug offenders increase predatory crime by wasting prison cells without much influencing the price or availability of drugs.
- Police tactics to disrupt certain kinds of flagrant drug dealing can reduce crime even if they do little to reduce drug consumption.
- Using the probation and parole systems to coerce abstinence among persons under their supervision could greatly reduce crime committed to buy drugs and the violence and disorder incident to drug dealing.
- Although heroin is much cheaper now than it was ten or twenty years ago, it remains hard to find for most consumers in most areas of the country. Keeping it that way by moving aggressively against emerging retail heroin markets will tend to reduce crime.
- If, as seems to be the case, marijuana acts as a substitute (in the economic sense) for alcohol and cocaine, then anything that reduces the effective price of marijuana relative to that of alcohol or cocaine will tend to reduce crime.

While this list of relatively firm conclusions is short, each item on it is of potentially great significance. If drug abuse control policy were made primarily for practical reasons, and primarily with an eye to the control of predatory crime, such policies might be close to its center, and the result would probably be a substantial reduction in crime.

However those who rely for their careers on the support of the public have found that, like Calvin Coolidge's preacher in his attitude toward sin, they can get along on drugs and crime by being "against it." Only a change in public attitudes is likely to remedy that situation, and such changes are not, alas, brought about by essays on policy analysis.

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Mr. CONDIT. Thank you very much, doctor. We appreciate it.

Dr. Kleber is from Columbia University. And we appreciate your being here this morning.

STATEMENT OF HERBERT D. KLEBER, M.D., EXECUTIVE VICE PRESIDENT AND MEDICAL DIRECTOR, CENTER ON ADDICTION AND SUBSTANCE ABUSE, COLUMBIA UNIVERSITY, NEW YORK, NY

Dr. KLEBER. Thank you, Mr. Chairman, members of the committee.

Mr. CONDIT. Let me remind witnesses, if you want to read your entire statement, that is absolutely OK, but you can submit those for the record and paraphrase your statement, and then we will have an exchange of dialog at the end of this.

Dr. KLEBER. I should like to express my thanks to you and the members of the committee for inviting me to address the important topic of drug abuse, which I consider to be the major public health problem of our time. In the interests of time I would request that my full testimony be submitted for insertion into the record, including my recent article in the New England Journal of Medicine on drug policy on which much of my testimony is based.

Mr. CONDIT. Absolutely.

Dr. KLEBER. Thank you.

My remarks will address the points requested in the letter; namely, the current and emerging drug trends and how best to cope with them within the limits of your committee's jurisdiction.

Recognizing that total elimination of drug use and abuse is unrealistic, the goal of policy for many years has been the reduction of such use combining supply and demand reduction programs. There has been progress toward that goal, primarily in reducing nonaddictive use, but unfortunately addictive use remains much too high.

The sharp decrease over the past decade in illegal drug use from 24 million current users in 1979 to 11.4 million in 1992 represents a dramatic cultural shift which has yet to be widely recognized. Progress was a result of a variety of forces—parent groups, community organizing, improved education prevention efforts, the media, especially the efforts of the wonderful partnership for a drug free America headed by Jim Burke, drug-free workplace initiatives by industry, and strong antidrug national leadership. The decline has had very beneficial effects in our schools, neighborhoods, and workplaces. Many who would have gone on to become addicts have not done so.

Unfortunately, addicted or heavy drug use remains much too high. It is embedded in crime, child neglect, family violence, school dropout, homelessness, AIDS, health care costs, urban decay, and economic competitiveness. Until we reduce such levels and the experimentation that leads to them, individual tragedies and profound social problems will continue to undermine the quality of our lives.

There are periods where drug abuse prevalence is high and epidemic. As the use wanes and becomes more endemic, disadvantaged people who have fewer resources are more likely to maintain

use, a function of both greater availability and fewer opportunities and social resources, as my colleague Mark Kleiman pointed out.

For example, while in the mid-1980's the majority of cocaine users were white, in recent years crack addiction has especially afflicted our poor minority communities. Although epidemics follow patterns, in a large sense the rapidity and extent of the decline is influenced by a variety of factors. Progress is possible but not inevitable, and could be reversed as witness the recent rise in marijuana and LSD use.

There are two ways to diminish drug use, supply reduction and demand reduction. Neither works well without the other. As someone who has been doing treatment and prevention for 30 years, I can assure you, it is very hard to do them where there are drug sales on every corner and in schools.

Let me turn now to trends. I believe that the causes of the recent rise are varied. Some represent short-term trends; others, unfortunately, may be longer-term trends.

I will start with marijuana and the psychedelic drugs. Recent studies report a rise in marijuana, LSD, mescaline, and PCP. These drugs not only pose risks in their own right, but historically their increased use has been followed by increased use of drugs such as cocaine. It is not as simple as these people who say "well, marijuana isn't that dangerous" would like us to believe. Historically, when marijuana use rises, so does use of drugs such as LSD, cocaine, and heroin. At this time I cannot tell whether the rise in the use of these substances is a short-term trend which will turn down in a few years. New patterns are emerging.

For example, we are seeing more marijuana use on college campuses combined with cocaine use, a phenomenon called LACE. We are seeing use of marijuana with malt liquor by younger individuals. I believe the increase in these drugs is due to the following factors.

One, decreased media attention to the harmful effects of these drugs and, conversely, increased media glamorizing of this use by rock groups, rap groups, and assorted others.

Two, decreased exposure to messages of the partnership for a drug free America. I was recently at a meeting of that organization, and one of the charts that Jim Burke put up showed how the decline in the amount of contributed time to the partnership has been paralleled by a rise in use of drugs and at the same time a decrease in perceived risk.

Three, insufficient attention to the problem of drug use in general by our national leaders. There have been many opportunities to talk about drug use in the context of violence and in the context of health care costs. I think that not enough advantage has been taken of those opportunities.

Four, conflicting messages about the legal status of drugs from administration sources which can cause confusion among the population as to drugs' perceived harmfulness.

Five, the difficulty in general in doing prevention in the decline phase of an epidemic when fewer students are directly exposed to the casualties of drug use. I worked in high schools in the 1970's. You didn't have to tell kids how dangerous marijuana use was. They saw around them kids wandering the halls stoned. As drug

use decreases, you see fewer such casualties, and so it becomes eminently possible for kids not to think that these drugs are harmful until use rises again and casualties rise again.

And, finally, increased availability and decreased price of these drugs, especially marijuana. For example, a few years ago marijuana was selling as high as \$400 an ounce; it now ranges from \$65 an ounce in the Southwest to over \$100 in New York City. I can't help but believe that market forces do have some effect and that if decreasing prices of heroin are causing increased heroin use, decreasing prices of marijuana are related to increased marijuana use.

Let me turn to cocaine. Levels of nonaddictive use of cocaine appear to be stable. The cocaine snorter still reflects the profile of the seventies and eighties, primarily white and working class or higher in income. Crack smokers, on the other hand, are more likely to be poor and members of minority groups in their twenties or thirties, and, an especially ominous trend, an increasing number of women. In a number of cities now, the number of women crack users outnumber the number of men, and I think we are going to see more in the way of pregnant cocaine abusers as a result of that.

Crack is usually used in combination with alcohol, marijuana, and tranquilizers. Cocaine injectors tend to use heroin; snorters tend to use alcohol and marijuana. Although there seems to be some slight increase in heavy cocaine use, as measured by emergency room data, there are both increases and decreases in cocaine use among arrestees. I believe the emergency room data may reflect not a true increase in the number of such users but more casualties among this heavy long-term group due to the continued availability of high-quality and relatively low-priced cocaine, especially in the crack form, and a continued shortage of adequate treatment programs, especially for crack.

My prediction is that cocaine use will gradually decline over the remainder of the decade and that by the year 2000 the currently estimated 2.1 million cocaine addicts will have diminished to about 1.25 million if adequate treatment is available.

Finally, a word about heroin. As Mark Kleiman pointed out, there is a rise in heroin purity, availability, and use, and decrease in price in the Northeast and West especially, less so in other parts of the country. The increased concern about AIDS has led to many users, especially in the Northeast area, smoking or snorting the drug instead of injecting.

A recent study in New York City indicated about 50 percent of the individuals seeking treatment for heroin detoxification were no longer injecting but were snorting or smoking. Such noninjection makes it psychologically easier to start, removing the needle barrier and letting the individual delude himself that such use is not dangerous or addicting. Unfortunately, one can become just as addicted or die of an overdose from these noninjecting routes as well.

New heroin users at this time appear to be primarily individuals switching over from cocaine to heroin. The good news is, as of yet we are not seeing an increase of any major proportion in heroin use in adolescents, a pattern we saw in the sixties and early seventies. As such, they tend to be older than those earlier group of initiates. If this pattern remains stable, the rise in heroin addiction will be

contained. If use increases significantly among adolescents, we should expect to see marked rises in heroin use overall.

A substantial topic of concern recently in the media—I think I get about 5 to 10 calls a week from TV, press, et cetera—has been the so-called rise in middle class heroin use, fueled by talk about Wall Street executives, entertainment stars, athletes, and suburban housewives. It is important to keep this in context and not repeat the mistakes of “cocaine-chic” glamorizing of the early 1980’s that helped fuel the cocaine epidemic.

Stimulant epidemics tend to end with increased heroin and sedative use as the users burn out. Middle class heroin use is not new; it has been with us for decades. For every Kurt Cobain, there was a Janis Joplin.

While there appears to be some increase now in middle class heroin use, it is not of the magnitude that the stories suggest, even though, unfortunately—and I am sure we will hear more from the other speakers—the epidemiology of heroin use remains the most difficult and the poorest understood of our epidemiology. Estimates range from 600,000 to 1 million. My own guess is that it is toward the lower end of that range, and I believe we will see an increase of about 200,000 over the next decade.

For those who are concerned about the increase in middle class heroin use, I commend to you this article in *Newsweek*, called “Middle Class Junkies.” It described everything that you are hearing in today’s papers. The only problem is, it was written on August 10, 1981. It had the same kind of quotes that you read about now. Not much as changed, including the remarks I gave back then.

Finally, in terms of other drugs, I don’t believe we are going to see any new epidemics in the next few years. There may be spotty outbreaks of this drug or that drug in that region or this region, but overall I believe that the major drugs we will be contending with for the remainder of this decade are those we are already contending with; namely, marijuana, cocaine, heroin, and LSD, and, to a lesser extent, the amphetamines. There may be minor rises in drugs like MDMA—ecstasy.

Let me conclude with a few recommendations. There appears to be no evidence that the agencies under your purview, the DEA, other parts of the Justice Department, and the Coast Guard, will be better able to intercept or prevent the distribution of these dangerous drugs in the next few years as compared to the past years. Although these agencies are staffed by some of the most hard working and dedicated individuals I have ever met, our borders are too porous and the ways of bringing in drugs too numerous. These agencies must continue their fight, but a better balanced approach is needed, continuing efforts on the supply side while substantially increasing efforts on the demand side.

The DEA in particular should be commended for the substantial efforts it has made in aiding prevention efforts. It has, for example, a demand reduction coordinator in every region of the country.

I believe the current ratio of supply to demand funding at the Federal level is flawed. I applaud the current administration’s attempt to move it to 59/41 instead of 65/35. I believe 50/50 would be even better. Next, we need to substantially increase treatment,

Where this committee comes in is treatment in the prison system. The agency I work with, the Center on Addiction and Substance Abuse, headed by our former head of HEW, Mr. Joseph Califano, is now using funds partially from the Department of Justice and partly from the Robert Wood Johnson Foundation, to do a study of individuals who have had treatment in prison, including both Federal and State prisons, and what happens to them when they come to the community, trying to provide a coordinated effort of treatment, housing, vocational, and educational efforts. Our hope is that in the five cities that we are doing this we will be able to show that such concentration on these hardcore individuals will pay off.

As Mark Kleiman noted, this group of hardcore individuals carries much of the social pathology, and if we focus on them we can make substantial progress. We also, of course—and this is not in your jurisdiction—need to do much more about the pregnant addict. We need to expand research. It is a disgrace that we spend so little on this. The National Institutes of Health spend \$4 billion for research on cancer, cardiovascular disease, and AIDS, and less than 20 percent of that on substance abuse, which is the largest single cause and exacerbator of those three conditions.

We need to do prevention, and again I think it is a disgrace that Congress cut over \$100 million from drug-free schools. I am hearing from schools all over the country that they will have to cut back substantially in their prevention efforts.

To conclude, while major progress has been made in reducing some aspects of drug use, the decline is uneven both as regards locale and groups, and the continued use of illegal drugs and resultant social problems are still too widespread and, in fact, increasing in some places.

None of the things I have mentioned, and I would dare to guess none of the things that any of my colleagues will mention, will quickly solve the problems. Continued pressure from Justice, from DEA, remains necessary, but we at the same time need to improve our efforts on the demand side.

Thank you.

[The prepared statement of Dr. Kleber follows:]

DRUGS IN THE '90s: EMERGING TRENDS

Rep. Gary A. Condit
Chairman, Information, Justice,
Transportation and Agriculture Subcommittee
of the Committee on Government Operations
Wednesday May 25, 1994

Testimony By:

Herbert D.Kleber, M.D.

Executive Vice President
The Center on Addiction and Substance Abuse
at Columbia University

and

Professor of Psychiatry
Director, Division on Substance Abuse
College of Physicians & Surgeons
Columbia University
New York State Psychiatric Institute

Testimony of Herbert D. Kleber, M.D.

DRUGS IN THE '90s: EMERGING TRENDS

Recognizing that total elimination of drug abuse is unrealistic, the goal of policy has been the reduction of such use, combining supply and demand reduction programs, in order to minimize individual and social problems. There has been substantial, although insufficient, progress towards that goal, primarily in reducing non-addictive use, but addictive use remains high. Marijuana use, for example, peaked in 1979, and in spite of the recent increase by high school students, remains at its lowest levels since the early seventies. Nonaddictive use of cocaine peaked around 1985 and current 30-day use is down more than 70 percent since then, from 5.8 million to 1.3 million. In general, most drug experts and historians agree that we are in the decline phase of a drug epidemic that began about 30 years ago. The sharp decrease over the past decade in illegal drug use--from 24 million current users in 1979, to 11.4 million in 1992--reflects a dramatic cultural shift which is yet to be widely appreciated. Progress was a result of a variety of forces: parent groups, community organizing, improved education and prevention efforts, the media (especially The Partnership for a Drug-Free America), drug-free workplace initiatives by industry, and strong anti-drug national political leadership. The decline has had beneficial effects in our schools, neighborhoods and workplaces. Many who would have gone on to become addicts have not started use. Unfortunately however, drug abuse remains one of the nation's most critical domestic problems, embedded in crime, child neglect, family violence, school drop-out, homelessness, AIDS, health care costs, urban decay, and economic

uncompetitiveness. Until we reduce current levels of addiction, and the experimentation that leads many to that end, individual tragedies and profound social problems will continue to undermine the quality of lives. Most people are notoriously poor judges of their own addiction liability. In 30 years of interviewing and treating thousands of heroin and cocaine addicts, I have met few who anticipated addiction when starting. The overwhelming majority believed initially they would have the will power to use on a casual basis. Some do; many do not. The more that use, the more casualties that develop.

There are two ways to diminish drug use: supply reduction and demand reduction. Supply reduction involves all the laws and activities aimed at decreasing availability, from the source to the sale to the final consumer. Since crop eradication, interdiction or domestic law enforcement have never been able under democracies to totally eliminate availability, the more common outcome is some limit on availability, higher prices, and lower purity. Demand reduction includes those activities aimed at making drugs psychologically unavailable, since we can't make them physically unavailable. It includes prevention for those not yet in trouble, treatment for those already dependent, and research to improve both. Certain regulations or laws also have a demand reduction effect, e.g. pre-employment drug testing. Likewise, law enforcement activities such as monitoring drug use for addicts on probation, or compelling treatment can be seen as demand reduction. The goal of both supply and demand activity is to keep use as low as possible, to minimize social harm recognizing that total elimination is not possible.

Viewed historically, there are periods where prevalence is high and epidemic. As use wanes and becomes more endemic, disadvantaged groups, who have fewer resources, are more

likely to maintain use. This is a function of both greater availability and fewer opportunities and social resources. For example, while in the mid-1980s, the majority of cocaine users were white, in recent years crack addiction has especially afflicted our poor minority communities. Although epidemics follow patterns in a large sense, the rapidity and extent of the decline is influenced by a variety of factors. Progress is possible, but not inevitable, and can be reversed, as witness recent increases in marijuana and LSD use.

The Center on Addiction and Substance Abuse at Columbia University (CASA), founded in 1992 by our former Secretary of H.E.W., Joseph A. Califano, Jr., has been studying the impact of substance abuse on the health care system. A recent Medicaid study, carried out by my colleague, Jeffrey Merrill, showed that approximately 1 out of every 5 dollars that Medicaid spends on in-patient hospital bills is related to substance abuse. On the average, patients with substance abuse as a secondary diagnosis are hospitalized twice as long as patients who have the same primary diagnosis but do not have a substance abuse problem. Numbers, if anything, underestimate the total cost to the Medicaid system because they do not show the cost of treating the victims of alcohol- and drug-related accidents and crimes, or the cost of teen pregnancies that occur because one or both partners were high. Nor does the study account for underreporting due to physician concern about confidentiality. We estimate, in short, that at least 140 billion dollars in health care costs, out of the total \$900 billion health care budget, is related to substance abuse. Not to its treatment, but to failure to adequately prevent and treat it!

Current and Emerging Trends

Under the impact of a variety of factors, certain types of drug use have begun to rise. I believe the causes of this rise are varied, with some representing short-term and others long-term trends.

Marijuana and Psychedelic Drugs

Recent studies by the University of Michigan "Monitoring the Future" survey, which looks at drug use in 8th, 10th and 12th graders have indicated a rise in LSD and marijuana. Ethnographic sources report a rise in marijuana, LSD, mescaline and PCP. There was a 4% increase to 26% in high school seniors in prior 30 day marijuana use in 1993, compared to 1992, accompanied by a decrease in the percentage of students who think marijuana poses a serious risk. It is important to keep in mind that these drugs not only pose risks in their own right, but historically increased use of them has been followed by increased use of drugs such as cocaine. At this time, I cannot tell whether the rise in use of these substances is a short-term trend which will turn back down again in a few years or whether we are in for a much longer and larger rise. New patterns are emerging. For example, use of marijuana with cocaine ("lace") by college students, and use of marijuana with malt liquor by younger individuals.

I believe the increase in these drugs is due to the following factors:

- 1) Decreased media attention to the harmful effects of these drugs and, conversely, increased media glamorizing of this use by various rock groups, rap groups and assorted others.

- 2) Decreased exposure to messages of the Partnership for a Drug-Free America. As their contributed free time has diminished, use has increased and perceived risk decreased.
- 3) Insufficient attention to the problem of drug use in general by our national leaders.
- 4) Conflicting messages about the legal status of drugs from administration sources which can cause confusion as to perceived harmfulness.
- 5) The difficulty in general in doing prevention in the decline phase of an epidemic when fewer students are directly exposed to the casualties of drug use as fewer students around them actually use.
- 6) Increased availability and decreased price of marijuana. For example, a few years ago, marijuana was selling as high as \$400 a ounce. According to recent sources, the range in the New York area now is from \$100 to \$600; in the Southwest, \$65 dollars; and in Florida, \$125 per ounce. This decreased price has been combined with increased availability and increased potency in many places.

Cocaine

Non-addictive use of cocaine appears not to be declining as in the past, but also not increasing. The cocaine snorter appears to still reflect the profile of the 1970s and '80s: more likely white and working class or higher in income. Crack smokers are more likely to be

members of minority groups, in their 20s or 30s, and an increasing number of women. Crack is usually used in combination with alcohol, marijuana, and tranquilizers; injectors tend to use heroin, and snorters tend to use alcohol and marijuana. There continues to be slight increases in heavy cocaine use, as measured by emergency room data, but both increases and decreases in cocaine use among arrestees. I believe the emergency room rise may reflect not a true increase in numbers of such users, but more casualties among this heavy long-term group, due to the availability of high quality and relatively low priced cocaine, especially in the crack form, and the continued shortage of treatment programs for crack and cocaine addicts. My prediction is that cocaine use will gradually decline over the remainder of the decade, and by the year 2000, the currently estimated 2.1 million cocaine addicts will have diminished to about 1.25 million, if adequate treatment is made available.

Heroin

There continues to be a rise in heroin purity, availability, and use, and decrease in its price. This is especially true in the northeast and west, less so in other parts of the country. The increased purity and concern about AIDS has led to many users, in the northeast area especially, smoking or snorting the drug as opposed to injecting it. A recent study of individuals seeking detoxification from heroin in New York City indicated that almost 50% were not injecting the drug. Such non-injection use makes it psychologically easier to start, removing the "needle barrier" usually present, and letting the individual delude him or herself that such use is not dangerous or addicting. Unfortunately, one can die of an overdose or become addicted from these non-injecting routes as well.

New heroin users appear at this time to be primarily individuals switching over from cocaine to heroin, rather than persons new to the drug use scene. As such, they tend to be older than the heroin initiates we saw in the 1950s, '60s, and '70s. If this pattern remains stable, the rise in heroin addiction will be contained. However, if use increases significantly among adolescents, then we should expect to see marked rises overall of heroin use. A topic that has received substantial attention over the past few months, has been the phenomenon of middle class heroin use. Newspapers, magazines and television trumpet this and talk about suburban housewives, Wall Street brokers, lawyers and entertainment stars. It is important to keep this in context, and not repeat the mistakes of the cocaine-chic glamorizing of the early 1980s that helped fuel the cocaine epidemic. The data that I have seen to date suggests that these middle- or upper-class persons described in the news stories are primarily switching over from cocaine. Use of heroin by other than the poor is hardly new. An article, for example, in Newsweek, August 10, 1981, was entitled "Middle Class Junkies" and talked about heroin in the middle class. We have to be very careful that in the process of describing this phenomenon, we do not sensationalize, helping to create the very problem that we dread. Stimulant epidemics tend to end with increased heroin and sedative use as the users "burn out." Middle class heroin use is not new; it has been with us for decades. For every Kurt Cobain, there has been a Janis Joplin. While there appears to be some increase now, it is probably not of the magnitude that the stories suggest. Numbers of heroin addicts, however, are one of the most difficult parts of drug-use epidemiology. Estimates range from 600,000 to 1 million. My own educated guess is toward the lower part of that range, and I believe we will see an increase of 200,000 or more over the rest of the decade.

Other Drugs

Although there are areas of the country where methamphetamine ("speed," "ice"), or MDMA ("ecstasy") are on the rise, I believe that, in general, we will not see any new drug epidemics in the next few years. There may be spotty outbreaks of this drug or that, in this region or that region, but overall, I believe the major drugs we will have to contend with for the remaining part of the decade are those we are already contending with, namely marijuana, cocaine, heroin and LSD, and to a lesser extent, the amphetamines.

Recommendations

1) **There appears to be no evidence that the agencies under the subcommittee's jurisdiction, the Drug Enforcement Administration, other parts of the Justice Department, and the Coast Guard, will be better able to intercept or prevent the distribution of these dangerous drugs in the next few years as compared to the past years.** Although these agencies are staffed by some of the most hard working and dedicated individuals I have ever met, our borders are too porous and the way of bringing in drugs too numerous. This is not to say that their efforts are not needed or should be eliminated. They must continue their fight, but a better balanced approach is needed. Such an approach would continue efforts on the supply side, while substantially increasing efforts on the demand side, where progress has been made in reducing use over the past half dozen years. The DEA should be commended for the substantial efforts it has made in aiding prevention efforts. It has demand reduction coordinators in every region and numerous retired agents assisting at the local community level.

2) **Flowing from the above point, I believe the current ratio of supply to demand funding at the federal level is flawed.** While the 59% supply, 41% demand ratio of the current administration proposed budget is an improvement over the previous 65/35 ratio, I believe a 50/50 ratio better approaches more realistically the nature of the problem and what is likely to be effective. It is important to keep pressure on off-shore production and distribution, as well as on criminal activities in this country associated with drug traffic, but the most cost effective way to decrease the number of hard core addicts is through the expansion of treatment.

3) **While there are estimates of 6 million individuals in need of treatment, the current system can only treat 1.4 million a year.** What is needed is system that can treat 2.5 to 3 million individuals a year. The short fall is a function of both inadequate federal increases and declining state funding. In order to fund an additional one million treatment episodes a year, there would need to be approximately 2.4 billion dollars above current expenditures. Even though the problem may ultimately be solved by health care reform in which treatment for substance abuse is readily available to all, this may be years in coming and much could be done in the interim to expand the system.

4) **The hard-core addict already involved in the criminal justice system should be a major target of new initiatives.** These include alternatives to incarceration, making effective treatment more available within prison, and new programs for the individual coming out of prison, especially for the first six to twelve months. CASA, with funding from the Department of Justice and the Robert Wood Johnson Foundation, is about to begin model programs in five

communities across the country. I have been impressed with some Federal and State prison programs I have recently visited as part of this initiative, but both the Federal Bureau of Prisons and State systems need to expand their efforts. This can be a very cost-effective way of decreasing the severe pathology addicts wreak on their communities.

5) **Another major group, with a large gap between need and availability, is the pregnant addict.** Only about 10% of such individuals are receiving badly needed treatment. As the rates of crack users shift towards more women, this group will become ever larger.

6) **While most substance abuse treatment has some effectiveness, the major issue is which treatment works, for which individual and the system in which it's administered.** A well run system needs to have an extensive evaluation at the beginning and a variety of approaches that can include rehabilitation, habilitation, comprehensive medical and psychological treatment and careful management along the way. So if the patient needs change or, if they do not do well on one approach, they can move to another. Badly needed is better data on which approach is better for which patient.

7) **One needs to distinguish between rehabilitation and habilitation.** The majority of drug users need rehabilitation. They have social and vocation skills and primarily need help with solving their drug problem. However, a substantial minority of drug dependent individuals need habilitation, which may require vocational and educational services, and for some, a stay in a long-term residential facility. Most health care reform plans do not take this distinction into

consideration.

8) **Research endeavors need expansion.** Improvement of treatment and prevention requires a much larger investment in research. It is a disgrace that so little is currently being spent for this. While the National Institutes of Health spend more than \$4 billion dollars for research on cancer, cardiovascular disease and AIDS, less than 20% of that amount is spent on substance abuse and addiction, the largest single cause and exacerbator of these three killers and cripples. At a minimum, research for drug abuse should equal 5% of the drug budget or approximately \$650 million dollars a year. There is exciting research going on in learning more about the effects of addictive drugs on the brain, pinpointing ways in which new medications can be developed, and developing such medications. There are also new advances in relapse prevention and other behavioral interventions that could improve our current techniques.

9) **Improved prevention is necessary.** A concerted effort is required, not just by government but by organized community partnership programs. The federal government should disseminate information on models that have worked, help with appropriate funding and insure accountability. Education about the dangers of drug use is a necessary but not sufficient component of prevention. The social influence model of education, when combined with comprehensive programs that include parents, community leaders and media campaigns has been shown to be successful. Unfortunately, recent cuts of over \$100 million in drug-free schools money has made it harder for schools to do appropriate drug education at a time of rising use. Since many factors such as poverty and family dysfunction, decrease the motivation to resist

drug use and are difficult to ameliorate in the short term, increased emphasis needs to be placed on programs that provide protective measures such as adult mentoring programs. CASA, with funding from the Department of Justice and a number of foundations, has set up demonstration programs for high-risk 11- to 13-year-olds in six cities.

Conclusion

Major progress has been made in reducing some aspects of drug use. Unfortunately, the decline is uneven, both as regards locale and groups, and the continued use of illegal drugs and resultant social problems are still too wide spread and in fact, increasing in some places. Increased emphasis on treatment, prevention, and research can improve our current state but will not quickly solve our problem. Continued pressure from agencies such as the DEA remains necessary. Certainly we need to resist any temptation to succumb to the seductive and dangerous siren song of legalization which would sharply increase the number of addicts and make our current social problems substantially worse.

HERBERT D. KLEBER, M.D.

Dr. Herbert Kleber is the Executive Vice President and Medical Director of the Center on Addiction and Substance Abuse at Columbia University (CASA). He also is Professor of Psychiatry at Columbia University College of Physicians and Surgeons and the New York State Psychiatric Institute, and heads a new Division on Substance Abuse within the Psychiatry Department.

Before coming to CASA and Columbia University in November 1991, Dr. Kleber served for two years as the Deputy Director of Demand Reduction in the Office of National Drug Control Policy, where he was responsible for that part of the national strategy having to do with reducing the demand for illegal drugs.

Prior to assuming that position, Dr. Kleber was Professor of Psychiatry at Yale University School of Medicine, Director of the Substance Abuse Treatment Unit at the Connecticut Mental Health Center and Chief Executive Officer of APT Foundation, the major treatment site for drug abusers in the New Haven area. Combined, these various programs have about 1,000 patients in treatment at any one time. In addition, he was Director of two National Institute on Drug Abuse (NIDA) funded centers at Yale; a Clinical Research Center to develop new treatments for opiate and cocaine abuse, and a Research Training Center to train for research careers in substance abuse.

Dr. Kleber has been a pioneer in the research and treatment of narcotic and cocaine abuse for more than 25 years. He received his undergraduate education at Dartmouth College, his medication training at Thomas Jefferson Medical School and his psychiatric residency at Yale University School of Medicine. Following his residency he spent two years at the U.S. Public Health Service Hospital in Lexington, Kentucky, the primary locus for narcotic addiction treatment and research for many decades. He then returned to Yale where he founded the Drug Dependence Unit in 1968.

Dr. Kleber is the author or co-author of more than 180 papers, chapters and books dealing with all aspects of substance abuse and the Editor of the recently published American Psychiatric Association Textbook of Substance Abuse Treatment. He has received numerous awards, two honorary degrees, and is on the editorial board of seven scientific journals. Prior to his position at the Office of National Drug Control Policy he had already played a major role in substance abuse policy development at the local, state and national levels.

Dr. Kleber is a Fellow of the American Psychiatric Association, the American College of Neuropsychopharmacology, the American College of Psychiatrists, the New York Academy of Medicine, the College on Problems of Drug Dependence, and the American Academy of Psychiatrists in Alcoholism and Addictions. He has served on three National Academy of Science Institute of Medicine Committees and chairs a number of Scientific Advisory Boards as well as governmental panels.



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OUR CURRENT APPROACH TO DRUG ABUSE — PROGRESS, PROBLEMS, PROPOSALS

Most drug-abuse experts and historians agree that we are in the declining phase of a drug epidemic that began about 30 years ago. Still, drug abuse remains one of the nation's critical domestic problems, linked to crime, neglect of children, family violence, incomplete education, homelessness, AIDS, high health care costs, urban decay, and diminished economic competitiveness. Until we reduce the current level of addiction and the experimentation that leads many people to that end, individual tragedies and profound social problems will continue to undermine the quality of our lives.

Most people are poor judges of their own susceptibility to addiction. In 30 years of treating thousands of heroin and cocaine addicts, I have met few who anticipated addiction when they started using drugs. Most believed initially that they would have the willpower to use drugs casually. Some do, but as more people use drugs, the problems related to their use increase. Laws and regulations arise from the need to diminish the numbers of drug users and their impact on society.

I will argue here that our current approach to drug abuse is far preferable to proposals either to legalize drugs or to refrain from enforcing the laws prohibiting their use. I will briefly summarize the current situation in regard to illicit drug use, the dangers of the alternative proposals, and recommendations for change that could improve our drug problem.

CURRENT POLICIES — PROGRESS AND PROBLEMS

With the recognition that drug abuse cannot be entirely eliminated, the goal of current drug-abuse policy is to reduce the use of drugs through a combination of activities to reduce supply and demand. There has been substantial progress toward that goal. Marijuana use peaked in 1979 and is now at its lowest level since 1973. Cocaine use peaked around 1985, and since then, the number of current users (defined as those who have used drugs in the previous 30 days) has dropped by more than 75 percent, from 5.8 million in 1985 to 1.3 million in 1992.¹

The sharp decrease in illegal drug use over the past decade — from 24 million users in 1979 to 11.4 million in 1992 — reflects a dramatic cultural shift that has yet to be widely appreciated. Progress in reducing drug use has resulted from a variety of forces: parent groups, community efforts, improved education and prevention programs, the activities of the Media Partnership for a Drug-Free America, the establishment of drug-free workplaces, and strong national leadership. The decline has had beneficial effects in our schools, neighborhoods, and places of work. Many people who would otherwise have gone on to become addicts have not started to use drugs.

Prevention is not perfect. The effect of legal availability on the use of drugs, even if such use remains

illegal for youngsters, can be examined by comparing tobacco use with marijuana and cocaine use by adolescents over the past decade. Despite greatly increased publicity about the dangers of smoking, stepped-up prevention programs, and the prohibition of television advertisements for cigarettes, tobacco use among adolescents barely declined from 1980 to 1990,² yet marijuana use declined dramatically during the same period (Table 1). In 1980, users of the two substances were almost equal in number; 10 years later, half as many students were using marijuana. The decrease in the use of marijuana did not lead to an increased use of alcohol. Both occasional and heavy use of alcohol declined — more than tobacco use but much less than marijuana use. The legal availability of tobacco and alcohol for use by adults and the corresponding social attitudes about the use of these substances make it much more difficult to prevent their use by adolescents.

Problems certainly remain. The inadequate availability of treatment programs has kept casualties associated with heavy "crack" cocaine use on the rise,³ although the number of new crack cocaine users appears to have been substantially reduced, which bodes well for the future.⁴ The supply of high-quality heroin and the shift to heroin use by some burned-out cocaine addicts have led to some increase in heroin addiction. Crime, overcrowding of prisons and courts, and disease, especially AIDS and tuberculosis, remain major problems associated with addiction in many of our cities.

Large numbers of minority men are in prison, primarily for selling drugs or committing crimes to get money for drugs. As drug use drops, these numbers should drop sharply as well, if effective treatment is available for drug users in prison, with appropriate training and job opportunities after their release. Legalization of drugs would hit this group hardest, as it has in the case of alcohol.

Our current drug situation follows the pattern of earlier drug epidemics.^{5,6} As the use of drugs

Table 1. Use of Various Drugs by High-School Seniors.*

Drug	1980	1985	1990	1980-1990
	% of students			% change
Alcohol				
30-day prevalence	72	65.9	57.1	-20.7
Daily for past 30 days	6	5	3.7	-38.3
≥5 drinks in a row, previous 30 days	41.2	36.7	32.2	-21.8
Cigarettes				
30-day prevalence	30.5	30.1	29.4	-3.6
Daily for previous 30 days	21.3	19.5	19.1	-10.3
Half a pack or more per day	14.3	12.5	11.3	-21.0
Marijuana				
30-day prevalence	33.7	14.9	14	-58.4
Daily for previous 30 days	9.1	4.9	2.2	-75.8
Cocaine (excluding crack)				
30-day prevalence	5.2	6.7	1.9	-63.5
Daily for previous 30 days	0.2	0.4	0.1	-50.0
Crack cocaine				
30-day prevalence			0.7	
Daily for previous 30 days			0.1	

*Data adapted from Johnston et al.²

drops from epidemic to endemic levels, disadvantaged groups are more likely than others to continue using drugs because of their greater availability and fewer alternative opportunities. That is why minority communities want not only treatment facilities but also fair laws, justly applied, to reduce the horrendous toll of drug-related crime in their neighborhoods. The illegal open-air drug bazaars that flourish in southeastern Washington, D.C., and the South Bronx would not be tolerated in Georgetown or Scarsdale.

THE PROBLEMS WITH LEGALIZATION

Since current approaches have improved but not solved our drug problem, some people call for regulatory changes. Some do so from a misguided feeling of frustration: nothing is working, and the problem is getting worse. Others espouse the libertarian position: in a free society, people should be free to experiment with substances and suffer any consequences.⁷ Still others acknowledge that laws against the possession and sale of drugs may reduce their use but argue that such laws create more problems than they solve by leading to crime, violent drug wars, and wholesale imprisonment.⁸ The general thrust of all these arguments is that legalization would lead to decreased crime without a substantial rise in addiction and would therefore result in an overall benefit to society.⁹ Proposed schemes vary: legalize drugs completely and allow marketing similar to that of tobacco and alcohol, decriminalize personal use and possession of drugs, or allow a medical dispensation of heroin or cocaine to those already addicted. Detailed and persuasive rebuttals of all these positions have been made,¹⁰⁻¹⁵ and space does not permit their repetition here. Instead, some common problems of legalization will be noted.

The Effect on Use

The crime, community disruption, and individual destruction that result from illicit drug use are caused mostly by the use of cocaine, especially the crack form, and heroin. Most proponents of regulatory change argue that we should proceed gradually, starting with marijuana, a drug considered to be less dangerous, before going on to those that are considered more dangerous. The reality, however, is that those who favor legalization lack a comprehensive plan to deal with cocaine. Cocaine is the *bête noire* of the legalization movement. Unlike sedatives, which depress their own use for hours, the use of cocaine stimulates further use. Binges are common, often ending only when no more cocaine or money is available or when the body, overwhelmed by the effects of the drug and sleep deprivation, collapses. Since crack cocaine is nothing but cocaine hydrochloride, heated with baking soda and water, regulatory changes that made cocaine hydrochloride more available would do the same for crack. Given the pharmacologic properties of these stimulants, the argument that legalization would lead to only a minimal rise in use seems disingenuous.

There are over 50 million nicotine addicts, 18 mil-

lion alcoholics or problem drinkers, and fewer than 2 million cocaine addicts in the United States. Cocaine is a much more addictive drug than alcohol. If cocaine were legally available, as alcohol and nicotine are now, the number of cocaine abusers would probably rise to a point somewhere between the numbers of users of the other two agents, perhaps 20 to 25 million. A detailed systems analysis of the effect of different regulatory schemes on cocaine prevalence suggests that the number of compulsive users might be 9 times higher (range, 4.7 to 15.8) than the current number.¹⁶ Anyone can use cocaine and become addicted. Although a psychiatric disorder increases the vulnerability to addiction, it is not a prerequisite. When drugs have been widely available — as heroin was to U.S. soldiers in Vietnam or cocaine was at the turn of the century — both use and addiction have risen.^{17,18} This critical factor of availability speaks to the need for continued law-enforcement activities even while treatment and prevention efforts are increased.

The Effect on Crime and Other Social Costs

Crime would not decrease if drugs were legalized. If the cost of drugs were low, addicts would tend to spend more time using them and less time working, so they would continue to need to commit crimes in order to acquire money. If the total number of addicts rose sharply as availability increased, crime would also increase. Fewer crimes would be committed by each addict, but there would be substantially more crime overall. Drug-related social problems would also increase: disorders in infants of addicted mothers, psychiatric disorders, AIDS and tuberculosis, homelessness, auto accidents, and family violence. The only problems likely to decrease would be violence and crimes among drug dealers.

Prohibition of alcohol, it was argued in the 1920s, would almost eliminate crime and other social ills. The famous preacher Billy Sunday proclaimed, "We will turn our prisons into factories."¹⁹ Those who favor legalizing drugs appear to be just as unrealistic in arguing the opposite point of view, that making heroin and cocaine legally available will decrease crime and violence. If it were legally available, cheap crack cocaine, with its tendency to lead to paranoia and aggression, would result in more crime and violence, just as alcohol does.

Preventing Increased Drug Use by Children and Adolescents

Legalization, of course, would not be complete; few propose legalizing drug use by minors. Would we be any more successful in keeping cocaine or heroin away from youngsters than we have been with alcohol or tobacco? The lower cost of legalized drugs would increase their availability for use by youngsters. A gram of cocaine costs \$80 on the illegal market but less than \$10 to import legally. At \$10 a gram, a dose of cocaine would cost less than 50 cents — well within the reach of 10-year-olds with lunch money. If the

price of legalized drugs were kept high, illegal cartels would continue to undercut it substantially. Addicts would still need to commit crimes to support their habit, unless drug use was subsidized at clinics. If the price of drugs were substantially lowered to drive out the cartels, the drugs would become more widely available. The people most likely to use drugs would be the young, the poor, and those with psychiatric problems.

The introduction of crack cocaine in the mid-1980s illustrates these issues. Cocaine, until then primarily available only by the gram, making it expensive to purchase, suddenly became available in small doses at \$3 to \$5 a "rock." The use of crack cocaine exploded, especially among the poor and the young.

The fact that alcohol causes problems in greater numbers reinforces the point. If cocaine were legalized, the likely result would be no decrease in the problems related to alcohol abuse and a sharp increase in those related to cocaine abuse. As McAuliffe notes, those who use the higher number of alcohol-related deaths to argue for the legalization of cocaine ignore this point.¹¹

Marijuana and Other Drugs

Although marijuana is not as toxic or addictive as cocaine, like the latter drug, it can lead to a variety of physical, psychological, and social problems. Will we legalize 1 percent or 10 percent marijuana or very potent hashish? Marijuana is most hazardous to the well-being of those who are most interested in using it — the young. Its effects on short-term memory, motivation, and energy level can interfere with the cognitive and social development of adolescents. Legalizing marijuana would reverse the decline in its use by adolescents, who would obtain it from those over 21 or purchase it illegally themselves. This is especially likely since the cost (currently as high as \$400 per ounce) would sharply decline under legalization. What about lysergic acid diethylamide (LSD), phenylcyclidine (PCP), and similar drugs? Which of the many mind-altering drugs are we willing to legalize to change our psychic reality?

As Kleiman recently noted, "Until success is achieved in imposing reasonable controls on the currently licit killers, alcohol and nicotine, the case for adding a third or fourth recreational drug . . . will remain hopelessly speculative."²⁰

BETTER POSSIBILITIES FOR CHANGE

Substantial progress has been made in reducing some aspects of drug abuse but not others. I believe that the following changes would help.

Expanded and Improved Treatment

The most cost-effective way to decrease the number of hard-core addicts is to expand treatment. Crop eradication or interdiction activities cannot stem the flow of illegal drugs into this country.²¹ Although it is important to maintain some pressure against offshore production and distribution, as well as against drug

traffic in this country, the current federal ratio of expenditures to control supply and demand — 65 percent to reduce supply and 35 percent to reduce demand — is misguided. A 50:50 ratio is more likely to be effective.

Currently, we can treat only 1.7 million people a year, but 2.5 to 3 million need treatment. To rectify this shortfall, which is a function of both inadequate federal funding and declining state funding, would require approximately \$2 billion per year above current expenditures. Although the problem may be solved by health care reform if adequate substance-abuse treatment is available to all, a reform will take years to implement, and expansion of treatment for drug abuse is needed now.

Most forms of drug treatment are effective for some people. The question is which treatment works for which person and under what circumstances. A well-run treatment system requires an extensive initial evaluation, a variety of approaches and settings, and careful case management to move patients among treatment settings as appropriate. The intensity of a treatment is often independent of its setting.²² In addition, systematic research on outcomes is essential to improve the cost effectiveness of treatment and determine what works for whom and why. Such a system would be affordable, could be integrated into the mainstream of health care, and would save billions of dollars by offsetting costs. A recent study by the Center on Addiction and Substance Abuse suggested that treatment for drug and alcohol abuse, integrated into a managed system of overall health care, could be provided at a cost of \$60 per American per year.²³ This figure would need to be increased to allow for the vocational, educational, and psychosocial services required by a substantial minority of addicts.

New programs need to be developed for the two groups of drug users with the largest gap between need for and availability of treatment: hard-core addicts in the criminal-justice system and pregnant addicts. Only about 10 percent of the latter are receiving treatment. Initiatives for the former group include more rapid but less severe sanctions; alternatives to incarceration, including expansion of therapeutic communities and methadone maintenance; the provision of effective treatment programs in prison; and new programs for released inmates, especially during the first 6 to 12 months after their release, when recidivism is most likely.

Improved Prevention

Since the drug problem will ultimately be solved at the local level, adequate local resources and knowledge are essential. The 1989 National Drug Control Strategy (a report issued by the White House) was deliberately called national rather than federal to emphasize that federal efforts alone are insufficient.²⁴ A concerted effort is required, not just by government but by organized community partnership programs, especially those modeled after the Robert Wood John-

son Foundation's Fighting Back initiative (a 1988 program that funded drug-control efforts by broad-based community groups, including parent and service groups, schools, health care providers, and law-enforcement officials).

The federal government should disseminate information on models that have worked, help with appropriate funding, and ensure accountability. Education about the dangers of drug use is a necessary but not sufficient component of prevention. A recent review²⁵ concluded that the social-influence model and its variants showed the most promise in drug education. This model attempts to familiarize adolescents with the external and internal pressures to use drugs, provides answers to pro-drug arguments, and teaches techniques for resisting peer pressure to use drugs. This approach combined with parent programs, community-leader training, and media campaigns has been shown to be successful.²⁶

Since many factors (for example, poverty and familial dysfunction) decrease the motivation to resist drug use and are difficult to ameliorate in the short term, increased emphasis should be placed on programs that provide protective measures, such as adult mentors.²⁷

The importance of developing forms of prevention that are effective in the declining phase of an epidemic is underscored by reports of increased drug use and decreased perception of risk by eighth-graders.² As drug use declines, firsthand knowledge of associated problems declines, and the younger would-be users tend to have a more cynical attitude toward the messages of drug education.

Modification of Existing Laws

A judicial commission should examine possible changes in the mandatory minimal-sentencing laws. These laws, which were enacted out of frustration with increased drug-related crime, should be revised to deter or control the true "drug kingpins"²⁸ and to make better use of limited prison facilities. Over 40 percent of drug offenders serving five-year sentences in federal prisons are relatively minor participants in the drug trade, such as drivers and couriers in large transactions.²⁹ Likewise, state laws need to be modified to make drug-related penalties more consistent and fair.

Use of currently illicit drugs for medical purposes should be a scientific, not political, question. Proponents of "medical marijuana" argue that oral synthetic tetrahydrocannabinol, available under schedule II, is not sufficient to treat the side effects of chemotherapy for cancer or the AIDS-related wasting syndrome, that the whole marijuana plant needs to be given through smoking. This issue has become politicized: opponents fear that marijuana made available for medical use would become more available for illicit use, especially by adolescents, and that its image as a dangerous drug would be changed; proponents see the change as a first step in having marijuana use decriminalized.

The National Academy of Science or the National Institutes of Health should evaluate the evidence for the proposed medical uses of marijuana. If the evidence is persuasive, the drug can be moved to schedule II; if it is inconclusive, appropriate research can be conducted to resolve the question. Cocaine is a schedule II drug used in anesthesiology and otolaryngology, but it is still viewed as a very dangerous drug when used in a nonmedical fashion. Since marijuana is a complex mixture containing over 300 compounds, many not adequately characterized, and since it has been associated with harmful effects, the decision requires a careful risk-benefit analysis. It may be better, for example, to consider alternative routes for the administration of synthetic tetrahydrocannabinol. Whether a drug is moved to schedule II is a decision that should be made by the Department of Health and Human Services rather than by the Drug Enforcement Agency, as the current law provides, to reduce the suspicion that such decisions are not being made on scientific grounds.

More Research

Improvement of treatment and prevention requires a much larger investment in research. It is a disgrace that so little money is currently being spent for research and that recent increases have been lower than annual increases in the cost of living. There is exciting research in progress, including investigations of mechanisms of drug actions in the brain,³⁰ new behavioral interventions, and a search for new medications, such as a proposed anticocaine vaccine.³¹ At a minimum, research on drug abuse should equal 5 percent of the budget for drug control, or approximately \$650 million per year instead of the current \$425 million.

Center on Addiction and Substance Abuse
Columbia University
New York, NY 10019

HERBERT D. KLEBER, M.D.

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The following was omitted from the published article:

Conclusion

Drug policy is never perfect. Major progress has been made in reducing some aspects of drug use but the decline is uneven as regards locale and groups. The continued use of illegal drugs and the resultant social problems are still too widespread, leading many to despair that any progress has been made. Changing the legal status, however, is likely to reverse the progress and lead to substantial, even explosive growth, in use. Social ills would worsen and we would be left with an intolerable situation, harder to turn around. If the political will is there, steps to improve our current state are possible. They include increased emphasis on treatment, prevention and research as well as some modification of existing laws. Even the best changes will not quickly solve our problem, but the easy, rapid solution is, unfortunately, a fantasy.

Mr. CONDIT. Dr. Kleber, thank you very much for your testimony and for being here today.

Let's see. We have Dr. Reuter from the University of Maryland. Is that correct?

Mr. REUTER. That is correct.

I would ask that my testimony be entered into the record.

Mr. CONDIT. Without objection.

STATEMENT OF PETER REUTER, UNIVERSITY OF MARYLAND

Mr. REUTER. I will keep my remarks short and would like to address two issues, one related to interdiction, arising out of your jurisdiction with respect to the Coast Guard, and the other one with respect to investigations, given your DEA jurisdiction.

Much of the Federal Government enforcement efforts essentially raise prices of drugs. We want prices to rise because we assume, with shockingly little evidence, that this will, in fact, decrease use, both by driving current users into treatment and preventing some people from getting started.

When considering heroin, cocaine, and marijuana, we are dealing with drugs which have mature markets. The notion that we could do something that would actually prevent enough being available seems to be beyond our capacities. That would not be true for markets that were just starting. So we ask then of individual programs how much they can raise the price of drugs in this country given say, an additional million dollars expenditure.

That exercise of examining the marginal contribution of each kind of program hasn't really been done. One study that I was involved with about 5 years ago tried to understand what interdiction could do to raise the price, in particular of cocaine in this country, and essentially it argued that given how cheap cocaine was when it entered the country as compared to the price on the streets, interdiction was a very limited program. As somebody had said about 10 years earlier, it is rather like raising the price of steak in fancy restaurants by rustling cattle out in Montana. It is just a very implausible way of accomplishing this goal.

For various reasons, interdiction's share of the Federal drug control budget has declined quite sharply since the late 1980's. In fiscal 1989, it was estimated—and it is important to remember that these figures are just estimates, not budget appropriations—that about 22 percent of the Federal drug control effort went to interdiction. By fiscal year 1994, it was down to just over 10 percent, and if the fiscal 1995 request is enacted, it will be down to 9.2 percent. Most of that decline has been driven by changes in Coast Guard's internal allocations. The Coast Guard has cut its estimated expenditures on interdiction by about two-thirds over the last 5 years, representing, no doubt, increased demands for its services in other arenas, in particular Haitian refugees.

But given the decline that has occurred, there is a question now about how far we should go? Should interdiction share go still lower? And in thinking about that, I want to make two points. One is that we should think about interdiction as a uniquely Federal program, in contrast to most other things that the Federal Government does by way of drug control, and we should set it in the context not of the Federal drug control budget, of the much larger na-

tional drug control budget that you get by adding in what State and local governments spend on the same effort. According to a study that ONDCP sponsored last year, the State and local governments spend more than the Federal Government does. I believe the figures for 1991 were an estimated \$11 billion for the Federal Government and about \$14 billion for State and local governments.

So interdiction's share of the national drug control budget is now down below 5 percent, and there is a question whether that is, in fact, an appropriate level. I would suggest that an examination of how much it is contributing to the price of cocaine on the street—namely, how much interdiction is able to raise the costs on smuggling—is one of the activities that this committee should consider looking at.

With respect to investigations, I want to make a point which in some sense is beyond my research competence but comes out of some work that Mark Kleiman and I did in connection with the transition at the end of 1992. We looked at DEA's share of the Federal drug investigations budget. DEA is designated as the lead agency of Federal criminal investigations into drug markets. In fact, its share just of the narrowly defined investigations budget has fallen steadily and rapidly over the last decade.

In fiscal 1981, about 59 percent of Federal investigative resources went to DEA. By 1987 that was down to 46 percent. In fiscal year 1994, it was down to 33 percent. DEA's capacity to play a leadership role, I think, is being substantially eroded.

Why does that matter? Well, I have no particular brief for the management of DEA, I simply am not in a position to assess it. But DEA's mission is a drug control mission. This is different from criminal investigation. It is about making strategic decisions to manage drug markets. I believe that they are better qualified to do that than other agencies which have drug investigations simply as one of many activities that they undertake.

Now that the issue of merging DEA into FBI seems to have been settled, I would suggest that some consideration be given to transferring most of the resources the FBI gets for drug investigations back to DEA to give it a more central role in this area.

That issue is given some urgency if you look at figures on Federal court sentencing for drug offenders. As you know, the Federal courts have essentially been flooded with drug defendants. In 1980, there were 6,300. By 1992, there were 22,000. Moreover, the expected time served rose from less than 2 years to over 6 years. The result was that, whereas in 1980 something like 4,000 cell years of time were handed by Federal judges for drug offenders, by 1992 that figure was 87,000; it had arisen more than 20 fold, drug offenders now constitute more than half of the inmates in Federal prison.

If those were all serious drug offenders, perhaps someone would say that is good public policy. It is clear from studies by the Sentencing Commission, and also by the Department of Justice, that a substantial percentage of those in Federal prison, typically serving 4 to 5 years, are minor offenders classified as peripheral to a drug importation scheme, street level or below street level, dealers.

I believe that there are a number of dynamics with respect to the cooperation between State and local agencies and some Federal

agencies, perhaps including DEA but I suspect more involving others, that have led the courts to receive a large number of minor drug offenders. I believe that there should be some concern to ensure that the Federal courts are appropriately used against more serious offenders.

Finally, let me say one thing about the BJA grants program. In the 1980's, we were primarily concerned about the spread of drug use and the general national orientation was to make sure that no more people began use of drugs. In the 1990's, for reasons that we have heard discussed before, there has been a major change in attitudes, and I think our concern should be less with the spread of drug use itself than with the harms that result from drug use—AIDS, TB, crime, hepatitis, et cetera. That gives a different programmatic orientation, and, like Mark Kleiman, I believe that the BJA grants should be much more focused on ensuring that we do something to control those harms rather than focus on drug use itself.

Thank you.

[The prepared statement of Mr. Reuter follows:]

Testimony before the Subcommittee on Information, Justice, Transportation and
Agriculture, House Government Operations Committee

May 25, 1994

Peter Reuter

School of Public Affairs and Institute of Criminology

University of Maryland

Mr. Chairman, I appreciate the opportunity to testify before your subcommittee this morning.

MAIN POINTS

My testimony makes three main points concerning the future of the drug problem and the roles of the Coast Guard and various Department of Justice agencies.

1. A rise in the rate of new heroin addicts is possible but even if it occurs the vast bulk of damage related to drug use over the new five years will be the consequence of the currently addicted. Primary concern should be the effects of policies and programs on those already addicted, in part because we can in fact do something for them and we have little notion of how to prevent new initiation into heroin addiction.

2. DEA's role as lead federal drug investigative agency has been steadily eroded over the last decade. Whereas in 1981 it received 59 percent of federal drug investigative resources, by 1987 that figure had fallen to 46 percent; in 1994 it was only 33 percent. Consideration should be given to transferring most of the drug investigative resources of the FBI to the Drug Enforcement Administration, helping increase the coherence of federal drug investigative strategy.

3. Interdiction's share of the federal drug control budget has been declining rapidly, from over 20 percent in the late 1980s to about 10 percent in the mid-1990s. That share should not be assessed in terms of the federal drug control budget but against the much larger national drug control budget. Using the crude proxy of how much interdiction contributes to raising the price of cocaine, the current budget share going to interdiction may be reasonable. However, interdiction holds little promise of making a significant contribution to control of heroin imports.

INTRODUCTION

The drug problem¹ has now become a staple entry in the lexicon of issues that need to be addressed by all levels of government. The term crisis is still used by some programmatic lobbies but the simple truth is that we have reached a stage in which, notwithstanding a 1993 upturn in self-reported use of marijuana by high school students, the problem of the next five years is fairly predictable and not very different from that of the last five years. About 2 to 2.5 million frequent cocaine users and heroin addicts will produce a significant share of the crime and disorder that will continue to plague inner cities; they will also play an important role in the transmission of various Sexually Transmitted Diseases, including AIDS, hepatitis and Tuberculosis. Though the epidemiology of drug use is still rudimentary, the best available models suggest that there will be only modest abatement in the number of persons dependent on cocaine and heroin (in their various forms) or in the problems they experience and cause as a result of that dependence. Large numbers of users, even frequent users, have managed to desist, but those who still continue may indeed be facing a chronic, relapsing, life-time condition. Finding ways of helping addicts to desist for longer periods and reduce their use of drugs when they relapse is probably the highest priority of drug policy.

The possibility of a new heroin epidemic in the 1990s has received considerable attention and other witnesses will no doubt address it in some detail. I would like only to caution as to the dangers of taking an increase in DAWN heroin ER mentions as a strong indicator of such an event. DAWN heroin mentions are driven by numerous factors in addition to the number of heroin addicts; their age, the availability of treatment, the potency of the drug and the price are all important. Older users may, as a result of chronic health problems, be more vulnerable to acute problems; we have an aging heroin addict population. Seeking admission to treatment is a major motive for entry to an ER; the closing of a methadone clinic in a community may increase ER heroin related episodes. More pure heroin is likely to engender more acute and chronic problems, as is lower price, because it encourages greater use of the drug. Given the dramatic decline in heroin prices in the late 1980s, along with an increase in price, a rise in DAWN figures might be expected, even absent any increase in the number of heroin addicts. Systematic analysis of the pattern of recent DAWN increases would help determine the importance of these other factors.

Enforcement

If the problem is primarily that of controlling the behaviors of current addicts, what contribution can be made by federal law enforcement agencies? In truth, they can do only a modest

¹For the purposes of this testimony, I will follow the convention of reserving the term "drug" only for those psychoactive substances that are illicit, though I recognize that for many policy purposes alcohol and tobacco should be included.

amount. Mostly they are in the business of trying to keep the prices high and perhaps create occasional short-term shortages. High prices discourage use, in part because they lead dependent users to seek treatment. Perhaps the more important effect in the past has been to discourage new users from moving beyond experimentation but with population attitudes still much more anti-drug than they were in the early 1980s, there is less danger of a major new epidemic and maintenance of high prices is consequently less important.

The Bureau of Prisons receives the largest drug-related appropriation (\$1,380 million for FY 1994²), one that threatens to grow very rapidly; the administration's FY 1995 request was for \$1,642 billion, a rise of 19 percent. The BoP has been saddled with a rapidly growing population of drug offenders, serving excessively long sentences; moreover, according to both the U.S. Sentencing Commission³ and the Attorney General's office⁴, a substantial percentage of those imprisoned are minor, non-violent offenders. Clearly at a time of concern about the availability of prison space this is a questionable allocation, quite apart from the equity concerns that are raised by the imposition of long prison terms for relatively minor offenses. There are many experienced drug dealers, at all levels of the market, so that incapacitation is not likely to make much difference to the operation of the cocaine and heroin markets. Perhaps long sentences serve to raise prices substantially by ensuring that participants require high compensation to enter such a risky activity but the weight of evidence and argument is against that effect being very substantial.

The Bureau of Prisons of course is the end of the criminal justice pipeline. Its populations are determined by the activities of all the other components of the drug enforcement effort, from investigation through prosecution and sentencing. The process can be traced in Table 1 which shows that the major source of the growth in federal drug related incarcerations has been the rise in expected time served of those convicted. Between 1980 and 1992, the number of drug-charged defendants grew by about 250 percent. The conviction rate, always high, rose somewhat from 75 percent to 83 percent. A higher percentage of those convicted received a prison sentence of more than one year. Sentence length rose significantly, from 55 months to 87 months. But the single most important source of the dramatic increase in cellyears (i.e. the expected amount of prison time resulting from sentencing in federal court in a given year) was the rise in expected time served, as a result of the elimination of the federal parole system. Whereas in 1985 offenders were expected to serve only one third of their sentence in prison, by 1992 the figure was nearly five sixths. Changes

²All budget figures are taken from the *Budget Summary: National Drug Control Strategy* (White House, 1994).

³U.S. Sentencing Commission *Mandatory Minimum Penalties in the Federal Criminal Justice System* Washington, August 1991.

⁴Department of Justice *An Analysis of Non-Violent Drug Offenders with Minimal Criminal History*. Washington, February 4, 1994.

in sentencing practices, much discussed in this session of Congress, are the single most important class of decisions that could relieve the burden on the Bureau of Prisons.

Table 1
Federal Drug Offenders, 1980-1992

	1980	1985	1990	1992
Number of Defendants	6,343	11,208	19,271	22,023
Number Convicted	4,479	9,231	16,188	18,319
(%of defendants)	75	83	84	83
Sentence to 1 year +	2,266	4,818	11,972	14,170
(%of convicted)	51	52	62	77
Avg Sentence Length	55	65	79	87
(months)				
Expected Time Served	22	22	66	74
(months)				
Cell Years	4,100	8,800	66,000	87,000

Source: Administrative Office of the U.S. Courts

However the behavior of investigative agencies and prosecutors also deserves scrutiny. For reasons that I can only speculate about, the investigative agencies and prosecutors continue to bring large numbers of minor offenders into the federal system. My guess is that it is less DEA, whose GDEP scoring system is designed to emphasize more serious offenders, than it is the non-specialized investigative agencies, such as the FBI, who are responsible for this. The emphasis on co-operation with state and local investigative agencies, the greater financial rewards available to those non-federal agencies when asset seizures occur in federal co-operative cases and the higher sentences available in federal court all provide incentives for agencies to bring numerous minor offenders with some connection to more significant trafficking cases into federal court.

One possible method for reducing the flow of minor cases would be to give DEA more of the investigative authority and resources. I make no assessment of DEA's management but do believe that it has a better institutional sense of what constitutes a sensible investigative strategy for federal drug cases, precisely because that is its mission. Drug enforcement is strategically different from most other kinds of law enforcement; it is about the management of markets and not the solving of crime. That requires not only different investigative techniques but also more sense of strategy about the allocation of resources

DEA's share of federal drug investigative budget has declined rapidly over the last decade. In 1981 it received 59 percent of estimated federal expenditures on drug investigations. By 1987 that figure had declined to less than half; by 1994 it was estimated to be only one third of the total. ONDCP also includes some of the DEA budget in the categories of Intelligence and International programs; DEA's share of those Intelligence has also declined, though the change is less steady and substantial. Its share of the International budget has been fairly stable. The figures are presented in Table 2.

Table 2
DEA Share of Federal Investigations, Intelligence and International Budgets

	1981	1987	1994
Investigations*	211.3	712.2	1,439.2
DEA share (%)	59	46	33
Intelligence*	23.1	47.2	163.4
DEA share (%)	90	77	45
International*	66.8	220.9	351.4
DEA share (%)	46	41	49

* In \$ millions.

Source: Office of National Drug Control Policy

Clearly other agencies bring important assets to the investigation of drug distribution. For example, the Customs Service has unique authority at the border (though cross-designation of DEA agents as Customs officers could give them much of the relevant resource) and the integration of border inspection with investigation is likely to be useful. Similarly, the FBI's general criminal investigative expertise, along with the breadth of its contacts with local agencies, give it a comparative advantage for some investigations. However, my impression is that both the FBI and the Customs Service have aggressively sought resources and authority at the expense of DEA and that the result is an unnecessarily fragmented investigative effort. Granting the FBI Director authority to deal with potential conflict is not likely to improve the situation. Transfer of much of the FBI's drug investigative resources to DEA seems a more sensible approach.

Interdiction

The Coast Guard is one of the three major agencies in the interdiction program, with an estimated expenditure of \$313 million in FY94 (slated to decline to \$262 million in FY95); the two others are Customs (\$460 million in FY94) and Defense (\$433 million). Total interdiction expenditure is one of two categories of drug control expenditures which is in decline, International programs being the other one. In FY94 interdiction expenditures constituted 10.7 percent of the

federal total, compared to 21.6 percent in FY89. The Administration's FY95 request lowers the share still further to 9.2 percent. As a share of total drug control expenditures, including state and local efforts⁵, the figure is certainly below 5 percent.

Much of the recorded decline in interdiction expenditures is the result of the Coast Guard's cut backs in interdiction efforts. The FY95 administration request is for only about one three eighths of the FY91 figure; inflation adjusted it is only about 30 percent. Presumably this reflects the increased concern with Haitian refugees and other Coast Guard duties. The Committee should also note that the numbers for drug interdiction activities represent not appropriations for those purposes but internal decisions by the Coast Guard, which estimates what share of its resources will go to interdiction; the estimate is not one which has been subject to scrutiny.

That decline since the late 1980s represents a growing disillusionment with interdiction as an instrument of drug control. Cocaine has been the primary target of interdiction and the landed price of cocaine fell throughout the 1980s even as the interdiction effort became more intense⁶. The question is whether this budget decline has gone too far.

It is useful to note interdiction's performance with respect to heroin and marijuana. Heroin shipments continue to be primarily in kilogram lots rather than hundreds of kilograms. It travels in commercial traffic rather than specialized small planes or boats. It comes from numerous regions of the world (via Nigeria, Mexico, Hong Kong, Bangkok and Western Europe). The result is that targeted interdiction is a minor part of the total heroin control effort. On the other hand, interdiction can claim considerable success with respect to marijuana. The low cost producer, Colombia, has essentially been locked out of the market; the United States market is serviced primarily by Mexican and domestic producers, who have much higher production costs. Though there is some indication of decline in the last two years, the price of marijuana is much higher than it was in the 1970s; that price increase may have contributed to the sharp decline in marijuana use through the 1980s, just as the recent increase in high school senior use may also have been influenced by the failure to maintain high marijuana prices.

Conclusion

Drug policy in the 1980s was driven primarily by a concern about the spread of drug use rather than by the harms, such as crime and AIDS, that result from drug dependence. Those harms are driven less by the prevalence of drug use generally than by the behavior of the relatively small

⁵ONDCP commissioned the Census Bureau to estimate state and local drug control expenditures in 1990 and 1991. The total for 1991 was \$16 billion, compared to about \$11 billion by the federal government. *State and Local Expenditures on Drug Control Activities* Washington, 1993.

⁶The difference between the landed price and export price represents the best single measure of interdiction's effectiveness, though it is certainly imperfect. The relevant measure of stringency is estimated seizures as a share of total imports. See Reuter, Crawford and Cave *Sealing the Borders* RAND, 1988.

population that uses expensive drugs frequently. In the 1990s it seems reasonable to concentrate more on that population and to ask federal agencies what their programs contribute to that effort. Keeping wholesale level prices high is less important than it was five to ten years ago.

Investigative agencies, as well as prosecutors should be encouraged to focus on drug distribution organizations that threatens institutions (those that are more effective and aggressive in corrupting police) and use violence, even if that means fewer arrests and seizures. The contribution of interdiction to the national effort also needs to be assessed against these targets, though it is important to remember that interdiction is uniquely a federal function, whereas high level domestic drug investigations are also conducted by state and local agencies.

Mr. CONDIT. Thank you, sir.
Ms. Falco.

STATEMENT OF MATHEA FALCO, DRUG STRATEGIES INSTITUTE

Ms. FALCO. Thank you, Mr. Chairman.

I am delighted to appear before you today on this very interesting panel to talk about emerging drug abuse trends. This committee is to be commended for your concern about this important issue—and for your efforts to improve government antidrug programs. I think we need to find stronger voices at many levels of our government, and I hope that you will make this a real priority.

I would also like to submit my complete statement for the record and just make very brief remarks. I would also like to submit for the record the Peter Hart Research Associates survey of national attitudes toward the drug problem and drug policy.

You have heard already this morning a very lucid description of the emerging drug trends as we see them. What is interesting among this panel is that although we come from very different professional backgrounds and even different political orientations, there is a remarkable degree of consensus.

I would just highlight a couple of things, particularly about young people getting into drug use. We do know that for the first time in a decade there are significant increases in illegal drug use. There is also substantial inhalant use among very young children, and I know that is not directly in your jurisdiction, but it might well be something the Justice Department should be concerned about in one way or another. One in five eighth graders have now used inhalants, and, as you know, they can make you high and, they can kill you very quickly.

The change in attitudes, I think, also needs to be emphasized. Teenagers now say that drugs and alcohol are less harmful than 4 years ago. They are much more tolerant of drug use, and adults also report similar changes in attitude. I do know that attitudinal shift should sound loud alarms in our homes, our communities, and especially in Congress.

We have heard a lot about heroin. I, too, seem to be on the media list for: What does it all mean? Whose fault is it? Is it the media that is making all these skinny young heroin addicts fashionable?

I would point out to you that availability and price have got to be very important, and I don't think people understand the dramatic degree of change. We know that heroin prices are a quarter of their 1981 levels, which is quite dramatic. Why has this happened? I would just footnote for you the enormous expansion in worldwide opium production which has played a major role in driving down prices.

The Department of State estimates that opium production has increased by two-thirds in the past 6 years from about 2,200 metric tons in 1987 to about 3,700 in 1993. Much of this, of course, comes from Burma, a country with whom we have virtually no relations. Burma has tripled opium production since 1987, and it now alone accounts for two-thirds of worldwide production. Other new sources are also emerging, including Colombia in our own hemisphere, and

several recently independent Central Asian republics, Khyrghistan, Uzbekistan, Kazakhstan, but Burma is the big source.

This boom in opium production is also relatively recent. I was the first Assistant Secretary of State for International Narcotics Matters from 1977 to 1981, and I was the architect for many of the programs which I now criticize today. In those days heroin was our No. 1 drug problem and our No. 1 policy target. But in those days, which really weren't all that long ago, worldwide opium production was about 700, 800 tons, less than a fifth of current production.

So I would just suggest to you—and I have talked about it in greater depth in the testimony—that as we think about solutions, law enforcement, interdiction solutions, we think about the larger context in which we are shaping these solutions. The world looks very different now in terms of drug production than it did in the late seventies when a lot of these policies really were put into place and formed the backbone of much of what we did in the 1980's.

I think we have to focus our resources on reducing the demand for drugs right here at home rather than trying to focus on foreign supplies as the major solution.

We have seen that in spite of massive investments in supply control efforts, particularly abroad in source countries, and in interdiction, that prices of cocaine and heroin have, in fact, fallen. The goals that those programs were designed to achieve were really not met. The brief victory that we had in the 1970's against Turkish and Mexican opium has not been experienced again since then. In the case of the cocaine countries, we have not even had a brief victory.

We have had some real progress in reducing recreational use of cocaine and marijuana. That has been fueled largely by attitudinal change which has been accelerated by the partnership advertising, by intensive prevention programs, and by a very large cultural change. Whether we are going to sustain that cultural change into the 21st century is not so clear.

I would note that this survey which I have had put into the record gives us a very interesting illumination of what the American people actually think about these problems. I was fascinated to learn that this problem which many of us feel has fallen off the radar screen of public policy is, in fact, a very real source of concern for Americans. I am sure you must be experiencing that in your own districts.

The survey which my organization, Drug Strategies, commissioned from Peter Hart to do is a national survey. It was done in February, and it looked at a wide variety of questions at a level of detail that is unusual. We don't have this kind of comprehensive information certainly for the last 5 years.

The single most interesting thing, from my perspective, was that almost one out of two Americans report personally knowing somebody who is or has been addicted to illegal drugs. We did not include the largest drug of abuse in this country, alcohol, in this survey. In the western States, particularly California, it is even more extensive; 51 percent of Californians know someone in their families, or their immediate communities, who have had this problem. That changes their attitudes dramatically. In fact, among this group with personal knowledge, 7 out of 10 say that their acquaint-

ance would be helped more by a supervised treatment program, than by being sent to prison. We also found very broad bipartisan support for expanding community efforts to address drug abuse and drug crime.

Seventy-four percent of the American people feel we should at the community level for education, treatment, prevention and law enforcement, rather than in putting our money. The Congress did cut some prevention funding last year, and that is being felt very acutely in the communities.

Americans prefer a balanced approach to drug abuse, and this in a year where the issue, particularly as it has been linked to drug crime and violence, has become very volatile politically, at least as it is reported in the press.

What was striking to me about this survey is how extraordinarily pragmatic Americans really are. What they care about is programs that work. They don't care if you label them liberal or conservative. Once you get beyond the ideological label, what they really care about is what is going to make a difference in the quality of lives in their communities. For example, the drug court—which I hope will receive substantial funding in the new crime bill—the drug court which 4 years ago was an experiment in a few cities has now become a model which is beyond the ideological debate. I would urge you, as you look at the kinds of responses needed for the 21st century, to remember that Americans in your districts and in this survey really care about progress. They are extremely pessimistic about the drug problem; 70 percent of them think the problem is worse than it was 5 years ago, and more than half think it will get still worse in the next 5 years; only 11 percent are optimists in this regard. Even sadder but not surprising is that only 5 percent believe that elected officials are doing everything possible to solve the problem. A good strong majority think that elected officials only claim to want to solve the drug problem but that in reality other problems always take precedence.

So I would urge you, gentlemen on this committee, to change the way Americans think about both our elected officials and about what we are doing about the drug problem. I know that you are concerned about it. I am delighted that you have convened this panel, and we look forward to the results of your deliberations.

Thank you.

[The prepared statement of Ms. Falco follows:]

Testimony

before the

**House Subcommittee on Information,
Justice, Transportation, and Agriculture**

of the

Committee on Government Operations

by

**Mathea Falco
President of Drug Strategies**

Wednesday, May 25, 1994

**Testimony
by
Mathea Falco
President of Drug Strategies
before the
House Subcommittee on Information,
Justice, Transportation, and Agriculture
of the
Committee on Government Operations
May 25, 1994**

I am delighted to appear before you today to testify on emerging drug abuse trends in the 1990s. Mr. Chairman, you and the members of your Committee are to be commended for your concern about this important issue and for your efforts to improve government anti-drug efforts.

As President of Drug Strategies, a new non-profit organization to find more effective approaches to the nation's drug problems, I share your concerns about emerging drug trends. As you know, the recent news is not good. Among young people, drug use has gotten worse, not better. For the first time in a decade, junior high and high school students report substantially greater use of marijuana, LSD, stimulants, and cigarettes. Inhalants--like paint thinner, aerosol sprays, and airplane glue--have become an epidemic among younger children. One in five eighth graders have used inhalants, which produce instant highs but can be lethal. More ominously, teenagers now consider drugs and alcohol less harmful than they did four years ago, and they are more tolerant of drug use.

Adults have similar attitudes: a majority see little harm in occasional drug use. These trends should sound alarms in every household in America and in every Committee in Congress.

Heroin use is on the increase, but in the 1990's, the drug is cheaper and purer than in earlier decades. Heroin currently sells on the street for about one-quarter of its 1981 price--and purity has jumped from 4 percent to 65 percent and higher. The increased purity means that people can now smoke or snort heroin where before they would have injected it. Freed from the fear of needles--and the possibility of contracting AIDS--many young professionals are experimenting with this new, more powerful heroin.

Hospital emergencies reflect this surge in use. Heroin-related overdose cases rose 44 percent in the first half of 1993 compared to the same period in 1992, according to the government's Drug Abuse Warning Network. The highly publicized heroin-related deaths of pop stars River Phoenix and Kurt Cobain in the last six months have apparently not made a dent in the drug's popularity. Last week, teenage tennis star Jennifer Capriati was arrested on drug charges along with two other teenagers who came to her room with heroin and crack cocaine. Dr. Robert Millman, a national expert on drug treatment and Director of Substance Abuse Services for New York Hospital-Cornell Medical Center, points out that for many affluent, educated Americans, heroin has become the new glamour drug, even though it produces severe addiction accompanied by frequent, deep depressions.

Why has heroin re-emerged in this cheaper, more powerful form? One major reason is rapidly expanding worldwide opium production which drives down heroin prices. The Department of State, drawing on the combined reports of the U.S. intelligence community, estimates that opium production has increased by two-thirds in the past six years: from 2,242 metric tons in 1987 to 3,699 tons in 1993. Much of this increase comes from Burma, which tripled opium production during that period and now accounts for two-thirds of worldwide production. New sources are also emerging, including Colombia in our own hemisphere, as well as several recently independent Central Asian Republics, particularly Khyrgyzistan, Uzbekistan, and Kazakhstan.

This boom in opium production is relatively recent. During the period I served as Assistant Secretary of State for International Narcotics Matters--from 1977 to 1981--heroin was the primary target of U.S. drug control policy, and the major drug of abuse in the country. At that time, however, worldwide opium production was estimated to be about 700 tons--less than a fifth of current production. Mexico, then the major source for our heroin market, launched an aggressive eradication campaign with U.S. assistance. This cooperative program successfully curtailed Mexican opium cultivation for several years. By 1980, the Mexican share of the U.S. heroin market dropped to 25 percent, compared to 87 percent in 1975. Unfortunately, Mexico has since re-emerged as a leading supplier for the U.S. with an estimated annual production of 40 tons of opium, which can be converted to four tons of heroin.

How should the U.S respond to the recent increase of drug and inhalant use among young people and prepare for the possibility of a new heroin epidemic in the 1990's? I believe we must focus resources on reducing the demand for drugs right here at home, rather than trying to curtail foreign drug production. Our recent history has shown that international programs to cut drugs off as close to their source as possible usually do not work. The only successes--Turkish and Mexican efforts to curtail opium production in the 1970's--were short-lived because other producers stepped in to satisfy American demand. In the case of cocaine countries, we have not enjoyed even a brief victory. Fueled by rapidly expanding production, wholesale cocaine prices have dropped by three-quarters since 1981.

What progress has been made is a result of reduced demand, rather than reduced supply. Despite the increasing availability of cocaine at ever cheaper prices, overall cocaine use has dropped by half since 1985, according to the National Household Survey on Drug Abuse. The numbers of Americans who report occasional use of cocaine declined sharply from 8.6 million in 1985 to 3.4 million in 1992. These declines reflected the growing awareness of cocaine's dangers, particularly after the overdose death of basketball star Len Bias in 1986 as well as the "deglamorization" of cocaine, accelerated by the highly visible Partnership for a Drug-Free America anti-drug advertising campaign. This trend reflects the power of health concerns, especially among better educated Americans, and negative social attitudes towards drug use.

But while occasional use has declined, drug addiction has not. In 1991, the Office of National Drug Control Policy (ONDCP) estimated that there were 1.8 million "hard-core" cocaine addicts, three times as many as estimated several years earlier. And the numbers of heroin addicts now exceed 700,000, compared to about 500,000 five years ago. The Institute of Medicine of the National Academy of Sciences estimates that nationwide there are 5.5 million serious drug abusers who need treatment.

As you know, to have any lasting impact on addiction, intensive, sustained drug treatment must be readily available to all those who need it. Less than a third of the nation's addicts can get treatment unless they can pay for private care. Even with President Clinton's proposed funding increase for 1995, treatment represents only 20 percent of the \$13 billion federal drug budget. State and local governments spend four times as much for drug enforcement as for treatment and prevention. Yet the National Institute of Drug Abuse estimates that every dollar invested in treatment saves ten dollars in reduced social costs.

As this Committee knows from its oversight of government anti-drug programs, the drug problem pervades our society, cutting across all social and economic groups. Two-thirds of all current illegal drug users (those who used drugs in the month prior to the survey) are employed and three-quarters are white. The National Household Survey on Drug Abuse found that when sociodemographic variables (like gender, education, occupation, and marital status) are controlled, there is very little difference in drug use by

blacks and whites. For example, without adjusting these variables, blacks are 3.9 times more likely than whites to use crack--a drug which is now linked to African-Americans in public perception. However, after these variables are controlled, blacks are only about 1.9 times more likely to use crack, a nonsignificant difference.

The pervasiveness of America's drug problem was confirmed by a nationwide poll conducted by Peter Hart Research Associates for Drug Strategies in February 1994. The poll found that nearly one in two Americans has been personally touched by the drug problem: 45 percent of those surveyed said that they know someone who became addicted to a drug other than alcohol. Not surprisingly, this personal knowledge sharply changes attitudes about how to deal with the problem. Seven in ten believe that their addicted acquaintance would have been helped more by entering a supervised treatment program than by being sent to prison.

The Hart poll found broad, bipartisan support for expanding community efforts to address drug abuse and drug crime. Three out of four Americans (74%) believe we should be investing more resources in our communities for drug education, treatment, prevention, and law enforcement programs rather than in source country programs and in efforts to cut off drug supplies coming into the country. Despite this support, large reductions in federal funding for prevention programs are forcing schools and other local government programs to scale back their prevention efforts.

At the same time, Americans prefer a balanced approach to combatting drug abuse.

While the public strongly believes (77%) that mandatory prison sentences for drug dealers will have a major impact in fighting drug crime, a large majority (64%) also think that job opportunities and training for drug offenders will make an important difference. Nearly half the public would divide anti-drug spending equally between law enforcement and prevention, education, and treatment, while one-third would put more funds into prevention, education, and treatment. Only one in five Americans would put more money into drug enforcement.

Not surprisingly, the public is pessimistic. Seven in ten Americans consider drug abuse worse now compared to five years ago. And more than half expect the problem to be still worse in five years. Only 11 percent expect any improvement. Very few people (5%) believe that elected officials are doing everything possible to solve the problem, and a majority (56%) think that elected officials only claim to want to solve the drug problem but that, in reality, other problems take precedence.

The 1994 Hart poll contains a wealth of valuable information on American attitudes towards the drug problem and drug policy. Drug Strategies plans to commission this poll annually so that we can measure changes in public perceptions over time. Mr. Chairman, I am attaching a copy of the poll for inclusion in the record of this hearing, so that others may draw on its findings.

In the past decade, we have learned that any lasting answer to the nation's drug problems must come from our communities. Government leadership is important,

particularly in shaping public attitudes, and public funding is necessary to make comprehensive programs possible. But it is in our families, our schools, our churches, and our places of work that we come to understand what drug abuse means in personal terms. As the Hart poll shows, Americans understand from their own experience that the drug problem requires a wide range of solutions. They know that lasting success is possible only if we can reduce demand. Above all, Americans want programs that work.

The efforts of this Committee can help restore public confidence that elected officials do take the drug problem seriously. Mr. Chairman, I would be pleased to help in any way I can.

Peter D. Hart Research Associates, Inc.

1724 Connecticut Avenue N.W.
 Washington D.C. 20009
 202-234-5570

On February 2 and 3, 1994, Peter D. Hart Research Associates conducted a survey among 1,001 Americans to explore attitudes toward the drug problem and drug policy. This memorandum summarizes the key findings from the survey.

Americans See the Drug Problem as Bad and Getting Worse

Seven in ten Americans see drug abuse as a greater problem now compared to five years ago, and fully half see it as a much greater problem than in the past. Four in ten Americans indicate that the problem has forced them to change the way they live, by making their homes more secure, staying inside at night, and avoiding certain areas.

Americans lack faith that the problem is being adequately addressed by elected officials, or even that it will improve. More than half (55%) expect the current problem to be still worse in five years, and only 11% expect any improvement. Few (5%) believe that elected officials are doing everything possible to solve the drug abuse problem, and a majority (56%) indicate that elected officials only claim to want to solve the drug problem but that, in reality, other problems take precedence.

Nearly half of Americans have been personally touched by the drug problem: 45% indicate that they know someone who became addicted to a drug other than alcohol.

Americans Reject One-Dimensional Solutions and Prefer a Pragmatic Approach to Drug Abuse That Includes Prevention and Treatment

Although political rhetoric often centers on tough law enforcement approaches, the public shows a reasonable, sophisticated, and balanced approach toward dealing

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with drug abuse. Asked for their ideal preferred allocation of money to fight the drug problem in their community, nearly half (46%) would divide funds equally between law enforcement and prevention, education, and treatment. One-third (32%) would put more funds into prevention, education, and treatment, and one in five (19%) would put more funds into law enforcement.

Likewise, the public's belief in the effectiveness of various measures to fight drug-related crime shows a pragmatic rather than ideological approach. The public strongly believes that mandatory prison sentences for drug dealers will make a major difference in fighting drug-related crime (77%), but 64% also think job opportunities and training will make an important difference. Mandatory sentences for drug users and supervising young people in schools that are open year-round and at night are seen as relatively ineffective approaches to drug-related crime.

On the whole, the public is evenly divided in its approaches to the drug problem: 46% prefer strict sentencing, law-enforcement, and interdiction approaches and 44% favor job opportunities, and drug treatment, education, and prevention.

Of the 45% of Americans who personally know someone who became addicted to drugs, seven in ten believe that their addicted acquaintance would have been helped more by entering a supervised treatment program than by being sentenced to a minimum prison term.

3

Americans Want the Problem Solved Here at Home

Drug interdiction strategies receive relatively low ratings on effectiveness. Six in ten (61%) believe that intercepting drugs on the seas or in the air is an effective way to stop the drug flow into the U.S., though only one-quarter believe this strategy to be very effective. Customs searches are seen as effective by a slightly higher number (67%) of Americans. However, approaches to eradicating drugs in foreign countries by destroying drug crops or providing funds to fight drug trafficking, are widely rejected--only one-third of Americans find eradication or providing funds to be very or even somewhat effective.

Asked to choose between funding interdiction efforts or spending the money in local communities on prevention, education, treatment and law enforcement, three in four Americans (74%) prefer to see the money spent at home.

Summary

Americans want real solutions to the problem of drug abuse, and grandstanding on this issue is likely to be met with a skeptical public response. Although Americans may be angry at those who abuse drugs, and especially at those who sell them, this anger does not prevent their endorsement of a balanced approach that mixes law enforcement with solutions aimed at preventing drug abuse and treating people who are addicted.

Peter D. Hart Research Associates, Inc.

Study #3942--page 1

PETER D. HART RESEARCH ASSOCIATES, INC.
 1724 Connecticut Avenue, NW
 Washington, DC 20009
 (202) 234-5570

Interviews: 1001 respondents
 Dates: February 2-3, 1994

FINAL

Study #3942
 Drug Strategies
 February 1994

48	Male
52	Female
[5]	

AREA		TYPE	SAMPLE POINT			FORM	DATE	1994
[6]	[7]	[8]	[9]	[10]	[11]	[12]	[13]	[14]

I'm calling from Peter Hart Research, the national public opinion polling firm. We are conducting a national survey. (CHECK BELOW FOR THE CATEGORY OF RESPONDENT YOU ARE SUPPOSED TO ASK FOR, THEN SAY.) Your number was selected at random, and in this household, I am supposed to speak with the (youngest/oldest) (man/woman) age 18 or over who is at home now.

PERSON TO ASK FOR

- ___ ASK FOR YOUNGEST
 ___ ASK FOR OLDEST

(REPEAT INTRODUCTION IF RESPONDENT IS NOT THE PERSON WHO FIRST ANSWERED THE PHONE.)

I have a few questions for you on several different topics. First, I would like to ask you some questions on your attitude toward the issue of drug abuse in America.

DS1a. Let's suppose for a moment that you were in charge of deciding how to spend an extra ten million dollars to fight the drug problem in your community. In which one of the following ways would you spend that extra ten million dollars?

All of it on law enforcement	7	[15]
Three-fourths on law enforcement and one-fourth on prevention, education, and treatment	12	
Half on law enforcement and half on prevention, education, and treatment	46	
Three-fourths on prevention, education, and treatment, and one-fourth on law enforcement	18	
All of it on prevention, education, and treatment	14	
None (VOL)	1	
Not sure	2	

DS1b. Please tell me which one of the following statements comes closest to your point of view on how elected officials are handling the issue of drug abuse. (READ STATEMENTS. START FROM THE BOTTOM ON EVERY OTHER INTERVIEW.)

Statement A: Elected officials are doing everything possible to solve the problem of drug abuse

OR

Statement B: Elected officials are trying hard to solve the drug abuse problem, but their approaches are not good enough.

OR

Statement C: Elected officials say they want to solve the drug problem, but in reality, they find other problems to be more important.

Statement A/doing everything possible	5	[16]
Statement B/trying, but approaches not good enough	35	
Statement C/say they are trying but find other problems more important	56	
Not sure	4	

DS2a. Have you or your family changed the way you live--such as when or where you shop, or taking security precautions in your home--because of the threat of drugs or problems caused by drug sellers and users?

Yes, have changed	39	CONTINUE	[17]
No, have not changed	60	SKIP TO	
Not sure	1	Q.DS3.	

(ASK ONLY OF RESPONDENTS WHO SAY THEY HAVE CHANGED THE WAY THEY LIVE IN Q.DS2a.)

DS2b. In what ways have you or your family changed the way you live because of drugs or the threat of drugs? [18-21]

RESPONDENTS WHO SAY VIOLENCE HAS CHANGED THE WAY THEY LIVE

Bars on windows, make sure windows and doors are locked	30%
Don't go alone after dark, do all shopping/errands during day	28
Security system in the house	14
Shop in different areas, stay away from certain malls, downtown	13
Become more cautious of your surroundings, more aware, more alert	10
Don't know; no response	4

(ASK EVERYONE.)

DS3. Compared to five years ago, do you feel that drug abuse today is a much greater problem, a somewhat greater problem, about the same, somewhat less of a problem, or much less of a problem?

A much greater problem	50	Somewhat less of a problem	3	[22]
A somewhat greater problem	20	Much less of a problem	1	
About the same	24	Not sure	2	

Peter D. Hart Research Associates, Inc.

Study #3942--page 3

DS4. Of the following two candidates for Congress, which one would you be more likely to support? (ROTATE DESCRIPTIONS.)

Candidate A wants to fight drug abuse with longer or tougher mandatory minimum sentences for drug users and drug dealers, more money for law enforcement, boot camps for first-time drug users, and wider use of drug testing.

Candidate B wants to fight drug abuse with longer or tougher sentences for drug dealers, court-supervised treatment for drug users, educational programs to prevent drug abuse, and intensive treatment for all those who need it.

Which candidate would you be more likely to support--Candidate A or Candidate B?

Candidate A/mandatory minimum sentences, law enforcement, and boot camps	31	[23]
Candidate B/stronger sentences, treatment, and prevention programs	63	
Depends on candidate (VOL)	2	
Not sure	4	

(FORM A)

DS5. Now I would like to read you some actions that have been proposed as ways to combat drug-related crime. For each one, please tell me if you think this will make a major difference in reducing drug-related crime, a minor difference, or no difference at all against drug-related crime. (FOR EACH ITEM, ASK:) Would (READ ITEM) make a major difference, a minor difference, or no difference at all in reducing drug-related crime? (START FROM THE BOTTOM ON EVERY OTHER INTERVIEW.)

	Major Difference	Minor Difference	No Difference At All	Not Sure	
Keeping schools open all year-round and at night, to provide supervised activities for young people	30	38	29	3	[24]
Improving job opportunities and training programs	64	26	8	2	[25]
Sending first-time drug offenders to a boot-camp program	58	28	9	5	[26]
Imposing mandatory prison sentences for drug <u>users</u>	44	34	19	3	[27]
Instituting rigorous, closely supervised treatment programs for first-time drug offenders	59	32	7	2	[28]
Providing drug treatment programs in prisons	49	34	13	4	[29]
Providing government-funded drug treatment for everyone who seeks it	49	35	14	2	[30]
Imposing mandatory prison sentences for drug <u>dealers</u>	77	16	6	1	[31]

(BOTH FORMS.)

DS6a. Which of the following statements about dealing with drug users comes closest to your own point of view? (READ STATEMENTS. START FROM THE BOTTOM ON EVERY OTHER INTERVIEW.)

Statement A: Do not prosecute drug users.Statement B: Require drug users to enter treatment programs that are supervised by the courts.Statement C: Send drug users to jail for sentences of less than two years.ORStatement D: Impose mandatory minimum prison sentences of more than two years on drug users.

Statement A/do not prosecute	3	[32]
Statement B/treatment programs supervised by courts	55	
Statement C/jail sentences of less than two years	11	
Statement D/mandatory minimum prison sentences of more than two years ..	25	
Combination (VOL)	3	
None (VOL)	2	
Not sure	1	

DS6b. Which of the following statements comes closest to your own point of view about how to deal with small-time, nonviolent drug dealers, who are selling drugs mainly to support their drug habit, as distinguished from big-time drug dealers who supply the street markets? (READ STATEMENTS. START FROM THE BOTTOM ON EVERY OTHER INTERVIEW.)Statement A: Do not prosecute small-time drug dealers.Statement B: Require small-time drug dealers to enter treatment programs that are supervised by the courts.Statement C: Send small-time drug dealers to jail for sentences of less than two years.ORStatement D: Impose mandatory minimum prison sentences of more than two years on small-time drug dealers.

Statement A/do not prosecute	2	[33]
Statement B/treatment programs supervised by courts	35	
Statement C/jail sentences of less than two years	21	
Statement D/mandatory minimum prison sentences of more than two years ..	38	
Combination (VOL)	2	
None (VOL)	1	
Not sure	1	

Peter O. Hart Research Associates, Inc.

Study #3942--page 5

DS7a. I would like to read you two statements about proposals to reduce drug-related crime. Please tell me which of the statements comes closer to your point of view. (READ STATEMENTS. ROTATE.)

Statement A: In dealing with drug-related crime, we need to emphasize prosecuting drug dealers and drug users, stricter sentencing, and stopping drugs before they are brought into the U.S.

OR

Statement B: In dealing with drug-related crime, we need to address the underlying causes by improving job opportunities and training, drug education, prevention, and treatment for everyone who needs it.

Statement A/stricter approach	46	[34]
Statement B/deal with the causes	44	
Some of both (VOL)	9	
Neither (VOL)	1	
Not sure	*	

(FORM B)

DS7b. Now I would like to read you several other approaches that have been used to stop the flow of illegal drugs into the U.S. For each one, please tell me if you consider this approach very effective, somewhat effective, only slightly effective, or not effective at all.

(READ EACH ITEM AND ASK:) Do you consider this approach very effective, somewhat effective, only slightly effective, or not effective at all? (START FROM THE BOTTOM ON EVERY OTHER INTERVIEW.)

	Very Effective	Somewhat Effective	Only Slightly Effective	Not Effective	Not Sure	
Intercepting drugs on the high seas or in the air, before they reach the U.S.	26	35	24	12	3	[35]
Customs searches and border patrols to block drug smuggling	27	40	19	12	2	[36]
Providing funds to foreign governments to destroy drug crops	16	19	23	39	3	[37]
Providing funds to foreign governments to strengthen their armies, police forces, and courts to fight drug trafficking	12	22	22	41	3	[38]

(FORM B)

DS7c. If a choice must be made, should we spend more money on the drug interdiction approaches that were just listed, or more money on programs in your community for drug education, treatment, prevention, and law enforcement?

Drug interdiction approaches	20	[39]
Education, treatment, prevention, and law enforcement	74	
Not sure	6	

Peter D. Hart Research Associates, Inc.

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(BOTH FORMS)

DS8a. President Clinton's health care plan currently includes making thirty-day drug treatment programs available for those who need such treatment. For many people who are addicted to drugs, thirty days will not be long enough for successful treatment. However, offering longer treatment would cost substantially more money. Should Congress increase the length of treatment that will be offered, even if it means tax increases or spending cuts in other areas, or should treatment be limited to thirty days?

Longer treatment should be offered	48	[40]
Treatment should be limited to thirty days	40	
Not sure	12	

(FORM A)

DS8b. Would you be willing to cut federal spending on (READ EACH ITEM) in order to spend more on the drug problem? (REPEAT QUESTION FOR EACH ITEM. START FROM THE BOTTOM ON EVERY OTHER INTERVIEW.)

	Willing To Cut Spending	Not Willing To Cut Spending	Not Sure	
Social Security	23	74	3	[41]
Roads and highways	46	49	5	[42]
Defense	52	43	5	[43]
Environmental protection	33	62	5	[44]
Education	10	87	3	[45]

(BOTH FORMS)

DS9. Now I am going to read you several proposals that have been suggested as ways of controlling the damage that is done to society's health and that of drug users themselves, because of illegal drugs. For each one that I read, please tell me if you would favor or oppose the proposal. (READ EACH ITEM, AND ASK:) Would you favor or oppose this proposal? (START FROM THE BOTTOM ON EVERY OTHER INTERVIEW.)

	Favor	Oppose	Not Sure	
Implementing needle exchange programs to reduce the spread of diseases such as AIDS	55	40	5	[46]
Allowing drug users to buy clean needles without prescriptions from pharmacies	37	59	4	[47]
Placing heroin addicts into methadone maintenance programs, which do not cure their addiction but allow addicts to become functioning members of society	49	44	7	[48]
Removing criminal penalties for the simple possession of needles and syringes	40	53	7	[49]
Instituting comprehensive treatment for addicted pregnant women throughout the course of their pregnancy, to ensure that their babies are born healthy	90	7	3	[50]

Peter D. Hart Research Associates, Inc.

Study #3942--page 7

(FORM B)

DS10a. Now I am going to ask for your estimate of how widespread certain drug-related problems are, in terms of percentages. For each drug-related problem that I read, please tell me the percentage of its occurrence--for example, zero, ten percent, twenty-five percent, fifty percent, seventy-five percent, ninety percent, one hundred percent, or any number in between.

(FOR EACH ITEM, ASK:) What do you believe is the percentage of (READ ITEM. RECORD ACTUAL PERCENT FROM 000 to 100. RECORD "NOT SURE" AS "999")?

	0-25%	26-50%	51-75%	76-100%	Not Sure	
AIDS patients who contracted AIDS from injecting drugs or from having sex with drug users	17	33	23	19	8	[51]
Health care costs that are due to drug abuse	25	35	17	11	12	[54]
Violent crimes, such as murder and rape, that are directly related to the drug problem	8	23	32	33	4	[57]
Crimes of property, such as car theft and burglary, that are directly related to the drug problem	9	26	32	30	3	[60]

(BOTH FORMS)

DS10b. Five years from now, do you feel that drug abuse will be a much greater problem, a somewhat greater problem, about the same, somewhat less of a problem, or much less of a problem?

A much greater problem	34	Somewhat less of a problem	9	[63]
A somewhat greater problem	21	Much less of a problem	2	
About the same	31	Not sure	3	

DS11a. Do you personally know someone, such as a relative, close friend, neighbor, or someone at work, who became addicted to drugs, other than alcohol?

Yes, know someone who became addicted	45	CONTINUE	[64]
No, do not know someone who became addicted	54		
Refused	-	SKIP TO Q.DS12a.	
Not sure	1		

(ASK ONLY OF RESPONDENTS WHO SAY THEY PERSONALLY KNOW SOMEONE WHO BECAME ADDICTED TO DRUGS IN Q.DS11a.)

DS11b. Was this person successfully treated for drug addiction, unsuccessfully treated, or not treated at all?

Successfully treated	32	[65]
Unsuccessfully treated	30	
Not treated at all	29	
Not sure	9	

(ASK ONLY OF RESPONDENTS WHO SAY THEY PERSONALLY KNOW SOMEONE WHO BECAME ADDICTED TO DRUGS IN Q.DS11a.)

DS11c. Which approach do you think would have been more helpful to this person--to be sentenced to a minimum term in prison, or to enter a supervised treatment program?

Prison sentence	15	[66]
Treatment program	71	
Neither (VOL)	6	
Both (VOL)	4	
Not sure	4	

(ASK EVERYONE.)

DS12a. Do you have any children who live at home with you? (IF HAVE CHILDREN AT HOME, ASK:) How old are your children? (IF DECLINE TO GIVE AGES, ASK:) Are your children under age 6, age 6 to 11, age 12 to 15, age 16 to 18, or over age 18? (ACCEPT MULTIPLE RESPONSES.)

<u>Yes, Have Children at Home</u>		[67]
Under age 6	20	CONTINUE
Age 6-11	18	
Age 12-15	12	
Age 16-18	8	
Over age 18	10	
<u>No, Do Not Have Children At Home</u>	51	SKIP TO
<u>Not Sure/Refused</u>	1	FACTUALS

(ASK ONLY OF RESPONDENTS WHO SAY THEY HAVE CHILDREN AGE 18 OR UNDER AT HOME IN Q.DS12a.)
DS12b. To the best of your knowledge, are drugs sold or used at the school of your oldest child?

Yes, drugs sold or used at oldest child's school	37	[68]
No, drugs not sold or used at oldest child's school	43	
Children not in school (VOL)	NA	
Not sure	20	

FACTUALS: Now I am going to ask you a few questions for statistical purposes only.

F1. Did you happen to vote in the 1992 presidential election?

(IF "YES," ASK:) For whom did you vote--George Bush, the Republican, Bill Clinton, the Democrat, or Ross Perot, the Independent?

Didn't vote	20	[106]
Voted for George Bush	27	
Voted for Bill Clinton	33	
Voted for Ross Perot	11	
Other candidate (VOL)	-	
Too young (VOL)	2	
Not sure/refused	7	

F2a. In politics today, do you generally consider yourself to be very liberal, somewhat liberal, moderate, somewhat conservative, very conservative, or do you think your views cannot really be described in those terms?

Very liberal	5	[107]
Somewhat liberal	17	
Moderate	23	
Somewhat conservative	23	
Very conservative	11	
Views cannot be described in those terms	18	
Not sure	3	

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F2b. Generally speaking, do you think of yourself as a Democrat, a Republican, an independent, or something else?

(IF "DEMOCRAT" OR "REPUBLICAN," ASK:) Would you call yourself a strong (Democrat/Republican) or a not very strong (Democrat/Republican)? (IF "NOT SURE," CODE AS "NOT STRONG DEMOCRAT/REPUBLICAN.")

(IF "INDEPENDENT," ASK:) Do you think of yourself as closer to the Republican Party, closer to the Democratic Party, or do you think of yourself as strictly independent? (IF "NOT SURE," CODE AS "STRICTLY INDEPENDENT.")

Strong Democrat	15	[108]
Not strong Democrat	16	
Independent/lean Democrat	9	
Strictly Independent	17	
Independent/lean Republican	8	
Not strong Republican	13	
Strong Republican	11	
Other	6	
Refused	1	
Don't know/nothing	4	

F3. What is the last grade you completed in school? (DO NOT READ CHOICES.)

Grade school	3	[109]
Some high school	9	
High school graduate	31	
Some college, no degree	16	
Vocational training, 2-year college	12	
4-year college/Bachelor's degree	16	
Some postgraduate work, no degree	2	
2-3 years postgraduate work, Master's degree	9	
Doctoral degree/law degree	1	
Not sure	1	

F4. How old are you? (IF REFUSED, ASK:) Well, can you tell me which age group you belong to? Are you in the age group 18 to 24, 25 to 29, 30 to 34, 35 to 39, 40 to 44, 45 to 49, 50 to 54, 55 to 59, 60 to 64, or 65 and over?

18-24	11	45-49	10	[110]
25-29	10	50-54	7	
30-34	11	55-59	6	
35-39	12	60-64	5	
40-44	11	65 and over	15	
		Refused	2	

F5. What type of work do you do? (WRITE JOB DESCRIPTION IN SPACE BELOW.)

Professional/manager	23	[111]
White collar worker	19	
Blue collar worker	25	
Farmer	1	
Student	3	
Homemaker	8	
Retired	17	
Unemployed	3	
Never worked/not sure	1	

(ASK OF ALL WOMEN:)

F6a. Do you work outside the home or not?

Work outside the home	30	[112]
Do not work outside the home	20	
Not sure/refused	2	

(ASK EVERYONE:)

F6b. Are you, or is any member of this household, a member of a labor union?

Respondent is union member	11	[113]
Other person in household is union member	7	
Nonunion household	79	
Not sure	3	

F6c. How would you describe the area in which you live—a large city, a suburb near a large city, a small city or town, or a rural or farming area?

Large city	24	[114]
Suburb	23	
Small city/small town	35	
Rural/farming area	17	
Not sure	1	

F7. In what religion were you brought up?

Protestant	49	[115]
Catholic	29	
Jewish	1	
Other	15	
None	4	
Not sure/refused	2	

F8. Are you white, black, Hispanic, Asian, or something else?

White	79	[116]
Black	10	
Hispanic	5	
Asian	2	
Other	2	
Not sure/refused	2	

F9. If you added together the yearly income of all the members of your family who were living at home last year, would the total be less than \$10,000, between \$10,000 and \$20,000, between \$20,000 and \$30,000, between \$30,000 and \$40,000, between \$40,000 and \$50,000, between \$50,000 and \$75,000, or would the total be more than that?

Less than \$10,000	8	[117]
Between \$10,000 and \$20,000	14	
Between \$20,000 and \$30,000	17	
Between \$30,000 and \$40,000	14	
Between \$40,000 and \$50,000	13	
Between \$50,000 and \$75,000	15	
More than \$75,000	10	
Not sure/refused	9	

Mr. CONDIT. Thank you. Ms. Falco.
Mr. Flynn.

STATEMENT OF STEPHEN FLYNN, BROOKINGS INSTITUTE

Mr. FLYNN. Thank you, Mr. Chairman.

I am delighted as well that this hearing has been convened. Unfortunately this issue has dropped off the political map in the United States, so it was very exciting for me to learn that these hearings would take place.

We have heard already this morning a great deal about recent domestic developments connected with this issue. I would like to focus in my remarks on the international dimensions of the drug phenomenon. Give the overseas role of the DEA, the Customs Service, and to a lesser extent, the Justice Department, I believe that consideration of recent international developments relevant to your work here.

Mr. CONDIT. Mr. Flynn, you take as much time as you need. You have been very patient.

Mr. FLYNN. Thank you, Mr. Chairman.

As with the other panelists I would like to deviate from my prepared remarks and present just the highlights so we can turn to your questions with your permission, I would like to have my formal remarks entered into the record.

Mr. CONDIT. Absolutely.

Mr. FLYNN. Mr. Chairman, drugs have always been and will continue to be a global problem. Yet the U.S. drug policy debate—past and present—rarely recognizes the international dimension of the drug issue beyond a concern for stemming the illicit overseas production and trafficking in drugs destined for our shores.

Recently even this supply side concern has been muted as the rising tide of violence and crime in American society has spurred a recasting of the drug problem as primarily a domestic policy challenge that requires closer attention to underlying social ills here at home.

Given the paucity of results from costly U.S. interdiction and source country initiatives, it is not surprising that a growing number of Americans, as reflected in the Hart poll mentioned by Mathea Falco, favor withdrawing the drug control battle lines to within our own national borders. But limiting the drug war to the home front is shortsighted.

Many of the experts on this panel have indicated that it is unclear if the scope of the drug problem here in the United States is undergoing much in the way of change. For experts who monitor the drug problem overseas there is absolutely no debate that this epidemic is becoming global in its proportions. There is no debate about the rise in production. There is no debate about the rise in trafficking activity in virtually every corner of the Earth, and there is no debate about the tremendous upsurge in consumption of drugs around the globe.

Why should policymakers in the United States care about these ominous international developments?

Well, first I think we should care because the goal of a drug-free America is a false promise as long as the drug epidemic spreads unchecked abroad. Heroin offers a case in point. U.S. enforcement

and public health officials thought they had achieved victory in the "war on heroin" in the early 1970's. But now heroin is widely available in cheap and extremely pure forms. This is largely due to changes in the European market for heroin that started to go flat in the late 1980's.

Having gone flat, traffickers decided to target an old market here in the United States.

Likewise, all drug fashions aren't created in the United States. Synthetic or designer drugs are often developed overseas but find their way into U.S. markets. For instance, a Methcathinone or CAT laboratories were discovered in Michigan in 1991. Its use spread rather swiftly throughout the northern Midwest.

CAT was developed by Soviet scientists some time ago and its illicit use was first documented in Leningrad in 1982. Today it is the second most abused drug in Russia.

Likewise, there is the dance club "rave" scene and the use of the drug MDMA, ecstasy that are becoming popular with some American youths. This scene started in Britain in 1991. Within a year it had made a trans-Atlantic passage and showed up in the United States.

So the idea we could sort of pretend that what is going on in the outside world won't affect what is happening here I think is clearly shortsighted. The fact is, overseas patterns of production, patterns of traffic, and patterns of consumption impact on the nature of the drug issue in the United States and we need to maintain an international perspective.

A second reason for why we should care about the global drug issue is that there are significant political, economic, and social consequences associated with the rapid spread of drug production, trafficking, and consumption overseas. We often fail to see these consequences because we tend to see the drug problem—and I think most of our discussion here this morning illustrated this—as either a U.S. public health problem or a U.S. law enforcement problem. Of course there is no question those are important public health components, but what I want to suggest to you as a result of some rather profound changes both with regard to the drug market but also because of the larger situation in the international community, the problem has, in fact, become more intertwined in larger U.S. interests.

This has really come about as a result of convergence of three forces in the late 1980's. One was that the demand for cocaine started to level off in the United States. Most cocaine use is primarily concentrated in the hardcore community with casual consumption among the middle class and upper middle class declining. Likewise in Europe, heroin consumption started to stabilize, while global production soared. So we had the first element, rising supplies.

The second development grew out of increasingly aggressive law enforcement efforts which brought about essentially a Darwinian evolution of trafficking organizations. What essentially happened is, the amateurs, the mom and pops, and the unlucky ones fill our jail cells, but the more sophisticated learners figured out that the way to be successful was not by forming essentially episodic criminal coalitions to evade law enforcement, Customs, Coast Guard, ef-

forts but was in fact to become much like a multinational corporation, to integrate the trafficking activity within legitimate transportation and legitimate banking and financial markets, to set up import-export companies to get the chemicals and so forth. In short, they started to resemble multinational enterprises with the important difference that they were not bound by domestic or international law, didn't have to worry about unions, didn't have to worry about paying taxes and so forth.

So by the late 1980's we had a rise in supply, and an increase in the sophistication of the drug organizations. They were more adaptive, more opportunistic, and they increasingly resembled other businesses in the international community.

And, finally, largely in the wake of post-1989 events, the profound changes connected with the end of the cold war, we had unprecedented opportunity both for legitimate business and illegitimate businesses to access new markets. The collapse of borders; in the case of the former Soviet Union, and East Europe and the voluntary removal of trade constraints with the European Community 1992 initiative.

The result is that the markets of the world have become much more open and they are also much more unregulated. As we slide increasingly into a time of global *laissez faire*, distinctions between licit and illicit activity essentially start to evaporate. Accordingly these multinational trafficking organizations have an unparalleled opportunity to target markets outside the United States.

Again, why should we care about these three developments? Let me suggest that there are several reasons important to our discussion here.

Fundamentally, a domestic response to the global drug scourge overlooks the political, economic, and social fallout associated with the rapid spread of drug production, traffic, and consumption overseas. For a growing number of societies, the rise in the global drug trade complicates and in some cases confounds the development of democratic institutions and the modernization of a national economy.

Drugs are estimated to be a \$250 to \$300 billion a year industry. Now these are very soft numbers, but the fact is, that lower number represents three-quarters of the size of the global petroleum industry. We are talking a sizable amount of money, and with that money these illicit enterprises can fuel political corruption, and do, in source and transit countries. They also give rise to powerful underground economies. These underground economies weaken the ability of national and international financial institutions to influence the economic destinies of the affected nations.

Right now we are facing in a fundamental foreign policy problem for the United States in how to bring East European and Russian economies through a transition process from centrally planned to free market. This requires the interaction with formal economic and political institutions, but to the extent that these institutions are being undermined by the tremendous upsurge in underground economies, which is a result in part of the growth of the drug trade, we have a problem: How do we make those transitions?

Clearly, there are important domestic problems attendant with widespread drug use—crime, lower levels of productivity, and ad-

verse health consequences that include the spread of HIV infection through intravenous drug use. These problems discourage foreign investment and add painful new burdens on societies that are often in a poor position to cope with them. Think about how Rwanda copes with the problem of rising drug abuse. Further, these kinds of problems further erode the legitimacy of governmental institutions and contribute to the rise in the number of societal basket cases we have around the international community.

It is a big industry—again, \$250 to \$300 billion. The drug trade also adversely affects an array of other important international challenges that involve vital U.S. interests. Consider the explosion of ethnic conflicts and civil wars which have appeared with the passing of the cold war era. While many ethnic and insurgent groups have seen the collapse of the Soviet bloc as an opportunity to pursue old causes, they must do so without the benefit of a superpower benefactor. Where do they get the cash to buy the arms to pursue their ends?

Not surprisingly, we can visit virtually every hot spot in today's international community and find it linked to the drug problem. The Croats and Serbs both have been implicated in the heroin trade that moves through the Balkan routes as a way to raise cash for their conflict. General Aideed in Somalia is a major player in the Horn of Africa khat trade which is a major drug of abuse in the Arabian Peninsula and in East Africa. The military dictators in Haiti, as we have learned, have had the ability to stand up to the U.N. economic embargo in part by the money generated by allowing cocaine shipments to pass through their country.

The warring parties in the conflict-ridden former Soviet republics of Azerbaijan, Georgia, Tajikistan, all have been implicated in the heroin trade that originates in the Golden Crescent region.

Now we have stepped a long way from domestic public health and law enforcement problems. We are witnessing a profound, I would suggest, change in this problem that is affecting vital U.S. interests. Closely connected to the rise of ethnic conflict and civil war is the challenge of weapons proliferation, another concern at the top of our foreign policy agenda, where the drug component is rarely considered.

Weapons often make their way to underground markets by the same routes and by the same traffickers used to move drugs. The arms-drugs nexus, of course, is not a new one. It has been well documented in the wars in Southeast Asia, certainly in Central America, and also in Afghanistan during the seventies and eighties.

Wars in those areas created virtual no man's lands through which drugs and arms passed unhindered, but the disintegration of the former Soviet Union represents a troubling new chapter in the proliferation story. Russia is now a burgeoning transshipment point for heroin and hashish from the golden crescent region, not a dominant one but a growing one, and it is becoming an important drug market in its own right.

These developments have been facilitated by an explosive growth of organized criminal networks, many of whom that have links to the Russian military units. According to Russian military sources, in 1993 there were 6,430 cases of thefts of weapons from military

depots, an increase of 60 percent from the year before, a tremendous increase from several years before that.

Russia has at least 30,000 nuclear warheads, 500 to 600 tons of highly enriched uranium, 100 to 200 tons of plutonium, and a cornucopia of sophisticated, deadly, conventional chemical weapons. In light of this, it would appear that the western security experts are properly concerned about lax security and the links between Russian military and criminal elements.

Drug cultivation and refinement has also been linked to another important issue preoccupying the American public in the global community, the environment. According to a recent U.N. report, the cultivation of cannabis, coca, and opium accounts for a growing share of the loss of tropical forest resources and the pollution of important waterways. In the Upper Amazon Basin, in the high mountain forests of Southeast Asia, each year thousands of hectares are cleared for cultivation and the construction of illicit airstrips. As refinement now takes place closer to production areas, hundreds of thousands of metric tons of chemicals find their way into these delicate ecosystems.

I think a very neglected feature of this problem has been the issue of chemicals. On average, two tons of waste byproducts are generated for every hectare of illicit coca. Where do they go? They go into the rivers, they go into the streams, they contaminate the water tables, in this very delicate region. The maceration and washing of coca leaf to make coca paste involves gasoline, kerosene, sulfuric acid, ammonia, sodium carbonate, potassium carbonate, and lime. When refining heroin in addition to these chemicals you even have hydrochloric acid.

The net result of all this is difficult to calculate, but clearly the kinds of environmental problems that have raised a great deal of concern in this country and mobilized vocal constituencies are exacerbated by the drug problem.

I will mention finally just the issue of health and the spread of disease. We need to spend little time on this, given what we know to be the close connection between HIV and AIDS infection and intravenous drug use. This challenge is not limited to the United States, but is a growing problem throughout the world.

In short, a close look at the international dimensions of the drug issue makes clear that we are essentially dealing with two sets of challenges. One set are the challenges connected with the drugs themselves—that is, the crime, enormous public health costs, and the human misery that accompanies drug addiction. The second set are the threats that stem from the drug trade, namely the ability for a multibillion dollar industry to operate with virtual impunity within the international system to corrupt governments, to disrupt economies, to fuel a host of developments inimical to the peaceful evolution of the 21st century global society.

With both these sets of challenges in mind, it becomes clear that a purely national response to the drug problem makes as much sense as a national response in ozone depletion. As would be the case with an unchecked global rise of greenhouse emissions, even the most aggressive domestic response could not insulate the United States from the far-reaching outcomes of an explosive growth of illicit drugs worldwide.

So what about DEA, Coast Guard, and Justice? Law enforcement alone, especially on an a national level, is clearly not the answer to either the domestic or the international dimensions of the drug issue. A global problem so closely connected to the political, economic, and social trends of the international system requires a comprehensive, multifaceted global response.

Nonetheless, the expertise and capabilities of the Drug Enforcement Administration, the Justice Department, and the Coast Guard can make an important contribution to developing such a global response to the scourge of illicit drugs. While their contributions are not the most essential they are important.

First, there is a tremendous ignorance among many foreign government—I found this in my own international travels—about the nature of the threat. For many, the challenge of drugs and drug trafficking are new problems for which they have no indigenous expertise or experience. Through overseas liaison offices, both Coast Guard and DEA officials, can play an extremely helpful role in educating their foreign counterparts. Similarly through international police training programs, the Justice Department has a real opportunity to get the message out to a new generation of law enforcement officers in post-communist and developing countries.

Second, there are other new things—there are always new things—to learn about the drug problem that require an overseas presence. The United States drug markets are generally at the end of the chain that start in remote regions of the world. Success at disrupting these distribution networks has often required that we be informed of activities far away from our national borders. Law enforcement liaison officers are able to work with host governments to gain this kind of information, and, as I stated from the outset, there are new drug uses and patterns constantly appearing outside. These same folks can play an important role with regard to giving us early warning indicators that can allow our public health and law enforcement people to get a jump by dealing with new drugs before they become epidemics here.

Finally, we can learn of novel new approaches that are actually taking place beyond our borders. An example of this is Europol, the creation of the European police, as well as the recent development of the Interpol communications channel. This latter development is an outstanding example, I think, of how police forces can tap the power of modern information age technology to obtain real time information on international criminal activity without being confounded by the traditional lethargic diplomatic channels.

Third, drug traffickers routinely exploit the gaps within or conflicts among vastly different national legal frameworks. Sovereign prerogatives, unfortunately, generally serve more as a barrier to international law enforcement than as a barrier to international crime.

Initiatives by the Justice Department and those funded by the State Department to assist governments, particularly those of post-communist states and developing countries in creating efficient and democratic criminal justice systems, can play an enormously important role by advancing norms and procedures that are in keeping with our own international standards of justice. The result is to im-

prove the chances from the outset that drug traffickers will face a common drug control front, not a divided and haphazard one.

Fourth and finally, an overseas presence by Justice, DEA, and Coast Guard will provide tangible evidence to U.S. friends and allies that we are not leaving them to their own devices to confront the vexing challenge of drugs. After all, it was the massive American appetite for illicit drugs that spawned the creation of the sophisticated modern trafficking organization and it was U.S. leadership that has been largely responsible for developing the current global prohibitionary regime. To turn our backs on the world would be an abrogation of responsibility at a time when the global community so clearly requires someone to take the lead.

Unfortunately, unless Congress mandates otherwise, overseas programs within these agencies will likely be the first victim of the shift now under way to move scarce resources from supply reduction programs to demand reduction programs. DEA, Justice, and Coast Guard will retreat to their core missions as a knee-jerk response to budgetary cutbacks. Further, they are likely to interpret a cutback in interdiction as a message that international programs in general have fallen out of favor.

In light of the drug trends in the 1990's and the implications I have outlined this morning, I believe such an interpretation would be inimical to the national interest. While scaling back on resources dedicated exclusively to drug interdiction is appropriate, I urge you to encourage and support legislation which would preserve an activist drug control role overseas for the drug enforcement agency, the Justice Department, the Coast Guard, and the U.S. Government.

Thank you very much.

[The prepared statement of Mr. Flynn follows:]

DRUGS IN THE '90'S: THE INTERNATIONAL DIMENSION

Testimony submitted to the Subcommittee on Information, Justice, Transportation,
and Agriculture, House Committee on Government Operations

Stephen E. Flynn

Annenberg Scholar-in-Residence, University of Pennsylvania
& Guest Scholar, The Brookings Institution

May 25, 1994

Testimony
 by
Stephen E. Flynn
Annenberg Scholar-in-Residence, University of Pennsylvania
& Guest Scholar, The Brookings Institution
 before the
House Subcommittee on Information,
Justice, Transportation, and Agriculture
of the Committee on Government Operations
May 25, 1994¹

Drugs have always been and will continue to be a global problem. Yet, the U.S. drug policy debate--past and present--rarely recognizes the international dimension of the drug issue beyond a concern for stemming the illicit overseas production and trafficking in drugs destined for *our* shores. Recently, even this supply-side concern has been muted as the rising tide of violence and crime in American society has spurred a recasting of the drug problem as primarily a domestic policy challenge that requires closer attention to underlying social ills here at home. Given the paucity of results from costly U.S. interdiction and source country initiatives, it is not surprising that a growing number of Americans favor withdrawing our drug control battle lines to within our own national borders.

But limiting the drug war to the homefront is shortsighted for two reasons. First, the goal of a drug-free America is a false-promise as long as the drug epidemic spreads unchecked abroad. If drug markets and consumption trends are free to develop elsewhere, it is naive to believe that those same patterns will not eventually make their way into a society as diverse and open as the United States. All recreational drug use does not originate in the United States. Methcathinone (CAT), for instance, has grown in three short years to become one of the most popular synthetic or "designer" drug in the United States today. CAT was developed by Soviet scientists and its illicit use first sprung up in St. Petersburg, Russia in 1982 where it has become the second most frequently used illicit drug in that country.² Similarly the use of the drug MDMA ("ecstasy") which is closely connected to the dance club "Rave" scene emerged into the public limelight in Britain in 1991. Within a year it had made the transatlantic passage to virtually every major urban area in the United States. Finally, the recent resurgence of heroin use in the United

¹ This testimony draws on the findings of the "Transnational Drug Challenge Project" currently underway at the Brookings Institution. The testimony was written with the collaboration of Paul Stares, a senior fellow with the Brookings Foreign Policy Studies Program and project co-director. The author is a tenured assistant professor in the Department of Humanities at the U.S. Coast Guard Academy. The views expressed are those of the author and do not reflect the official policy or position of the U.S. Coast Guard, Department of Transportation, or the U.S. Government.

² *Methcathinone (CAT) - A Baseline Assessment*, (Johnstown, PA: National Drug Intelligence Center, March 1994)

States, particularly among young people, can be attributed in part to its widespread availability in cheap and extremely pure forms--an outcome in part of rising production and the saturation of the European market which prompted drug traffickers to rediscover an old market.

Second, and perhaps more important, a domestic response to the global drug scourge overlooks the political, economic, and social fallout associated with the rapid spread of drug production, trafficking, and consumption overseas. For a growing number of societies, the rise of the global drug trade complicates and in some cases confounds the development of democratic institutions and the modernization of a national economy. Drugs are an estimated \$250-300 billion a year business which is at least three-quarters the size of the world petroleum industry. The enormous profits from this illicit enterprise fuel political corruption in source and transit countries. They also give rise to powerful underground economies, weakening the ability of national and international financial institutions to influence the economic destinies of the affected nations. The problems attendant with widespread drug use--crime, lower levels of worker productivity, and health consequences that include the spread of HIV infection through intravenous drug use--discourage foreign investment and add painful new burdens on societies that are often in a poor position to cope with them.

The global drug trade also adversely effects an array of other important international challenges that involve vital U.S. interests. Consider the explosion of ethnic conflicts and civil wars that have appeared with the passing of the Cold War era. While many ethnic and insurgent groups have seen the collapse of the Soviet bloc as an opportunity to pursue recidivist causes, they must do so without the benefit of a superpower benefactor. By either directly participating in or by providing protection for the production and trafficking of drugs, these groups can raise the requisite hard currency to pursue their political aims. Examples include the Croats and Serbs, both of whom have been linked to the flow of heroin destined for Western Europe via the "Balkan Route;" General Aidid in Somalia, who has for some time been a dominant player in the Horn of Africa "khat" trade; the military dictators in Haiti whose ability to stand up against the U.N. economic embargo has been strengthened by the money generated from allowing cocaine shipments to pass through their country; and the warring parties in the conflict-ridden former Soviet republics of Azerbaijan, Georgia, and Tajikistan, all of whom have been implicated in the heroin trade that originates in the Golden Crescent region.

Closely related to the drug trade's connection with ethnic conflict and civil war is its link to weapons proliferation. Weapons often make their way to underground arms markets via the same routes and by the same traffickers used to move drugs. The arms-drugs nexus is not a new one, as conflicts in Southeast Asia, Central America, and Afghanistan during the 1970s and 1980s have demonstrated. Wars in those areas created virtual no-man's lands through which drugs and arms passed unhindered. But the disintegration of the Soviet Union represents a troubling new chapter in the proliferation story. Russia is now a burgeoning transshipment point for heroin and hashish from the

Golden Crescent region and is becoming an important drug market in its own right. These developments have been facilitated by the explosive growth of organized criminal networks, many of whom have links with Russian military units. According to Russian military sources, in 1993 there were 6,430 cases of thefts of weapons from military depots, an increase of 60 percent from the year before. As Russia has at least 30,000 nuclear warheads, 500 to 600 tons of highly enriched uranium, 100 to 200 tons of plutonium, and a cornucopia of sophisticated and deadly conventional and chemical weapons, it would appear that Western security experts are properly quite concerned by lax security and the linkage between Russian military and criminal elements.³

Drug cultivation and refinement are also linked to another issue preoccupying the American public and the global community: the environment. According to a United Nations report entitled "Illicit Narcotics Cultivation and Processing: The Ignored Environmental Drama," the cultivation of cannabis, coca and opium accounts for a growing share of the loss of tropical forest resources and the pollution of important waterways. In the upper Amazon basin and in the high mountain forests of Southeast Asia, each year thousands of hectares are cleared for cultivation and the construction of illicit airstrips. As refinement now takes place closer to production areas, hundreds of thousands of metric tons of chemicals find their way into these delicate ecosystems. On average, two tons of waste by-products are generated for each hectare of illicit coca cultivation. In the process of maceration and washing coca leaf to make coca paste, enormous amounts of gasoline, kerosene, sulfuric acid, ammonia, sodium carbonate, potassium carbonate and lime are dumped on to ground and into nearby waterways, poisoning water supplies and destroying fisheries. Likewise, heroin refiners wreak havoc in their producing areas by aimlessly discarding lime, ammonia, tartaric acid, ammonium chloride, alcohol, acetone, acetic anhydride and hydrochloric acid. What the net result of all this will be is difficult to calculate. At a minimum, the surge in the supply of illicit drugs will add to the depletion of valuable and vulnerable lands, accelerate the loss and extinction of flora and fauna in genetically rich tropical regions, contribute to the loss of watershed compounding further socio-economic imbalances, and add to global atmospheric concerns as a result of the wholesale clearing of rain forest reserves.⁴

Finally, there is the issue of disease control. As the initial spread of AIDS suggests, viral epidemics are difficult to check when international air carriers fly between 600 and 700 billion passenger miles each year. By 1989, AIDS had been reported in 159 countries. Today, no country has been spared. Speeding infections along is their spread via intravenous needles shared by drug addicts, and subsequently from needle users to the general population through sexual practices. Among the hill tribes of Thailand for instance, heroin addiction is rampant and needles are extremely scarce. HIV infection has

³ The data and these observations on the proliferation risks connected with the rise of Russian organized crime are all drawn from Rensselaer W. Lee III's testimony on "Post-Soviet Organized Crime and Western Security Interests" submitted to the Subcommittee on Terrorism, Narcotics and International Operations, Senate Committee on Foreign Relations, on April 21, 1994.

⁴ *Illicit Narcotics Cultivation and Processing: The Ignored Environmental Drama*. A United Nations Drug Control Programme informational publication. Vienna: 1993

spread swiftly.⁵ As some of these young people leave the rural areas for Bangkok and make their living as prostitutes (male and female prostitution is widespread in Thailand) they add to the already high incidence of HIV infection in that city. As the major international gateway to southeast Asia, Bangkok, in turn, has served as one of the major sites for worldwide HIV contagion. Thus, one conclusion that can be drawn from the AIDS epidemic is that no country can effectively quarantine itself from new and resilient strains of destructive viruses in face of an increasingly mobile global population. Widespread drug abuse increases further our vulnerability to infectious diseases.

In short, a close look at the international dimension of the drug issue makes clear that we are essentially dealing with two sets of challenges. One set are the challenges connected with the drugs themselves; that is, the crime, enormous public health costs, and human misery that accompanies drug addiction. The second set are the threats that stem from the drug trade; namely, the ability for a multi-billion dollar industry to operate with virtual impunity within the international system, to corrupt governments and disrupt economies, and to fuel a host of developments inimical to the peaceful evolution of twenty-first century global society. With both these sets of challenges in mind, it becomes clear that a purely national response to the drug problem makes as much sense as a national response on ozone depletion. As would be the case with an unchecked global rise in green house emissions, even the most aggressive domestic response could not insulate the United States from the far reaching outcomes of an explosive growth in illicit drugs worldwide.

Before considering what all this might mean for the future drug control roles of the Drug Enforcement Administration, the Justice Department, and the Coast Guard, it is important that we step back and briefly assess how we got to where we are. Indeed, I am fervent in my belief that analysis should precede prescription--a notion which, when applied to drug policy more often than not receives only lip-service.

In the not so distant past, the international drug market could be largely characterized as one where criminals sought to link distant producers with consumers in the United States by developing essentially episodic schemes to evade customs and law enforcement agents. Understandably, we therefore limited the focus of our drug control exertions to stopping foreign suppliers from feeding the habits of our addicts and to reducing the crime and public health consequences of drug use in our communities. However, by the late 1980s, the global drug market underwent a profound transformation as a result of three converging developments that I outline in more detail below. First among these developments was that the cocaine market in the United States and the heroin market in Western Europe began to flatten out while production of illicit coca and opium poppies reached unprecedented levels and began to spill over into new areas in the developing world. Second, the most successful drug traffickers developed sophisticated

⁵ Peter Loverde, "Heroin in the Hills: Changing Patterns of Drug Dependency Among Thailand's Hill Tribes" in the Proceedings of the Community Epidemiology Work Group, June 1992 (Rockville, MD: DHHS Publication No. (ADM) 92-1958, 1992) 465-8.

organizations capable of evading even the more aggressive and advanced interdiction efforts designed to combat them. The traffickers accomplished this largely by developing the capacity to immerse their illicit activities into the international transportation, banking, and commercial sectors that service the legitimate global economy. Third, the political, economic, and social changes connected with the collapse of the post-communist world and the end of the Cold War generated new incentives and opportunities for creating new drug markets within and outside the traditional consumer nations.

In short, rising supplies generated new incentives to seek new markets, the evolution of the modern drug cartel provided new means to distribute globally, and the fundamental transformations underway in the international system created new opportunities to developing new markets. The traditional albeit crude characterization of the global market as being distinguished by Third World production and First World consumption is even less true today.

Drug Production in the 1990s

U.S. drug use survey data in the mid-1980s indicates that, after years of significant rise, casual consumption of cocaine, particularly among middle class and upper middle class Americans, began to level off. Similarly in Western Europe, heroin consumption began to stabilize if not decline in certain areas. Against this backdrop has been a persistent rise in drug production.

Beginning with the cocaine production trends, coca cultivation is no longer strictly concentrated in the Upper Huallaga valley in Peru or the Chapare in Bolivia. Cultivation has spread to virtually every region in Peru, to northwestern Brazil, southern Venezuela, and reportedly, even into remote regions in Nigeria. Refinement of coca paste into cocaine hydrochloride--once almost an exclusively Colombian activity--now takes place in the primary coca source countries of Peru and Bolivia, as well as the adjacent countries of Venezuela, Ecuador, Brazil, and Panama. Finally, recent seizures of coca paste in Lebanon and Italy indicate that cocaine refinement is no longer confined to the Western Hemisphere.

The practice of cultivating opium poppies have consistently demonstrated its geographical mobility. Illicit poppy cultivation that was once associated with the Golden Crescent countries of Iran, Afghanistan, and Pakistan; and the Golden Triangle countries of Laos, Thailand, and Burma is now spreading to other areas. In the past five years, Colombia, China, Vietnam, Cambodia, the Central Asian republics of the former Soviet Union, Ukraine, Bulgaria, and Romania have all join the ranks of opium producing nations. Refinement of opium into heroin, once limited to advance industrialized societies, now is accomplished more often in the developing world than the developed.

Cannabis, the most ubiquitous of drugs, is now being produced in new areas including Central Asia, and Sub-Saharan Africa. The Central Asian republic of

Kazakhstan with an estimated 138,000 hectares of wild-growing cannabis--approximately 5 times the recorded cannabis cultivation in Mexico and Colombia combined--gives some idea of the potential productive capacity of the region. In Africa, cannabis is being grown in the Saloum Islands and Casamance in Senegal, the San Pedro Forest in Ivory Coast, the banks of the Gambia River, the Black Volta Littoral in Ghana, the Nyungew region in Rwanda, and various regions in Togo, Benin, Nigeria, and Zaire. There has been also a recent resurgence in marijuana cultivation in Colombia. Even in the United States, large tracts of national forest and national park land are being used by illicit cultivators, potent new strains are being developed and grown in state-of-the-art greenhouses, and by some estimates, marijuana has become the number one cash crop for the states of Kentucky and California.

The production of synthetic narcotics such as methamphetamine, amphetamine, LSD, methaqualone, and methcathinone appears to be spreading. Laboratories in Taiwan and South Korea are the major source of "ice," a high-purity methamphetamine that was developed in the mid-1980s. Poland recently emerged as one of the largest producers of amphetamines for the European market, with police lab analyses indicating that nearly one quarter of the amphetamines seized in Western Europe originate in Poland. Underground laboratories for synthetic drugs have been discovered in Moscow, St. Petersburg, Sverdlovsk, and many of the other major cities in the former Soviet Union. Methaqualone (mandrax) is produced in laboratories throughout India primarily for the large market in southern Africa.

Drug Trafficking in the 1990s

Since the major markets for drugs have traditionally been at some distance from production areas, linking suppliers with consumers presents a significant logistical challenge. In recent years, the tasks of acquiring chemicals for the refinement of illicit drugs, transporting and distributing the finished contraband, and managing the enormous sums of cash involved have been conducted against a backdrop of an increasingly vigorous law enforcement regime designed to curb them. The result has been to create something of a Darwinian evolution in the drug trade where the unskilled and unlucky drug traffickers fill our prisons and the survivors have become sophisticated, highly adaptive and opportunistic organizations.

The Colombian organizations represent the prototype of the contemporary trafficking organization, having developed the capacity to conduct R&D, to manage large-scale refinement, transportation, distribution, and financial operations, to collect intelligence and to ensure operational and organizational security. Today, Colombian operatives can be found working outside the Western Hemisphere in Japan, Hungary, the Czech Republic, Poland, Germany, and throughout Western Europe.

A brief overview of how the Cali organization services the U.S. cocaine market provides a sobering insight into the trafficking challenge that confronts the international community. Contrary to popular belief, most drugs do not cross American borders on

low-flying Cessnas, aboard fast-moving "cigarette" boats, or among the belongings of illegal Mexican immigrants. Most reach their markets by way of commercial conveyances. Containerized shipments, bulk cargo, false documentation, and front companies conceal the movement of cocaine by water. By land, most cocaine crosses the U.S.-Mexican border in hidden compartments of tractor trailers and other vehicles or in commercial cargo itself.

The Cali organization uses international shipping centers in Central and South America, particularly in Brazil, Venezuela, Surinam, and Panama, to ship cocaine by sea to Europe and to the eastern United States. When commercial airlines are used, the drug is hidden on the plane itself, among perishable cargoes such as cut flowers, or among passengers who conceal it by placing it in luggage with false bottoms or in hollowed-out sneakers, by taping it to their bodies, or by ingesting by swallowing condoms filled with cocaine. Sometimes it is converted to liquid and smuggled in bottles of shampoo, mouthwash, and liquor.

Once the drug arrives, it is distributed by one of the dozens of Cali distribution cells throughout the country. Each cell, made up of 15-20 Colombian employees who earn monthly salaries ranging from \$2,000 to \$7,500, conducts as much as \$25 million of business a month. Each cell is self-contained, with information tightly compartmentalized. Only a handful of managers know all the operatives. The cell typically has a head, bookkeeper, money handler, cocaine handler, motor pool, and 10 to 15 apartments serving as stash houses.

Communications are conducted in code over facsimile machines, cellular phones, and pay phones. To eliminate any risk of interception, cellular phones are purchased and discarded, often two or three times a week. When a wholesale customer wants to make a purchase, a cell member is notified by a pager system. That cell member proceeds to a public phone and arranges a rendezvous site. He then gets, from the motor pool, a rental car that is returned to the rental agency after the transaction. The transaction itself, including travel receipts, is logged by the bookkeeper, and the money is turned over to the money handler to be shipped to the financial network set up by the cartel to hide and invest it. A favorite way to ship within the United States is the U.S. Postal Service's "Express Mail."

Once the cartel has received the money for its drug sales, it moves it into and through the legal financial system to conceal its origins. If a Cali cell broken up by federal authorities in December 1991 is representative, the Cali financial network must launder about \$200 million each year per cell. Money laundering typically involves three independent phases. First, drug proceeds are "placed," that is, to make deposits or to purchase monetary instruments or securities that can be turned into cash elsewhere. This is often done by hiring individuals known as "smurfs" to deposit the money in small denominations in as many banks and financial institutions as possible so as to defeat currency reporting requirements. Second, the money is "layered," or sent through multiple electronic transfers or other transactions to make it difficult to track and blur its

illicit origin. Finally, the source of the money disappears as it is "integrated," that is, invested into seemingly legitimate accounts and enterprises. To lower their exposure to law enforcement yet further, the Cali families more and more have contracted out these last two phases, requiring money handlers in Colombia to provide them the money up front, less a 10 - 15 percent commission, in return for providing these handlers the opportunity to launder and keep the full amount.

Despite their clear domination of the cocaine market, the Colombians are finding the drug trafficking field more and more crowded. They now fight for market share with Chinese, Azeri, Chechen, Italian, Lebanese, Nigerian, Pakistani, Polish, Russian, Turkish, and Vietnamese crime syndicates. In response to this competition and the perceived opportunity to exploit new markets, there is growing evidence of strategic cooperation among Colombian and other drug traffickers to realize greater economies of scale and to minimize risk by geographic and product diversification. For instance, there have been a number of confirmed reports of cocaine for heroin swaps between Colombian and Italian traffickers.

Exploiting New Drug Markets

If traffickers are able to make drugs readily available, there is substantial cause for concern that consumption would increase dramatically in the targeted population. Many of the risk factors associated with widespread use are becoming more prevalent as societies reel under the pressure of demographic forces that are overwhelming their resource base, and leaving citizens little hope for a better tomorrow. As the opportunity to scratch out a meaningful existence in the rural areas diminishes and urban areas must cope with the daily tidal wave of new migrants, traditional social and cultural institutions are losing their capacity to hold families and communities together. Into the void of weakened laws and norms, poverty and social disorganization, broken families, and limited educational or employment opportunities, drugs dealers are presented with a fertile climate to ply their wares.

There are reports of rising consumption in a growing number of developing and post-communist countries. In Pakistan, heroin users have grown from several thousands in the late 1970s to 2.5 - 3 million today. In China, after its virtual eradication in the early 1950s, today there are at least 1-2 million drug users with public security officials reporting 500,000-600,000 in the Guangdong province alone. Russian authorities estimate there are now 1-1.5 million users, and the consumption is growing at an alarming rate. In Poland, 75 percent of all alcoholics are also addicted to either licit or illicit drugs with use of a "home-grown" heroin derivative known as "kompot" growing rapidly. Iran has close to 1 million users despite extremely draconian efforts by the fundamentalist government to eliminate it. Egypt reportedly now has 750,000 - 1 million drug users. In the Western Hemisphere, virtually every Latin American and Caribbean country has reported a rise in drug consumption.

Access to these new markets has been facilitated in part by the tumultuous political changes connected with the passing of the Cold War era. Among the republics of the former-Soviet Union, and the countries of Eastern Europe, the once formidable border controls have virtually disappeared, and few resources are available to support criminal investigations and law enforcement activities. Further, the disturbing rise in ethnic conflicts and civil wars are creating new trafficking hubs where drugs and arms can be brought and sold with little risk of interference by governmental authorities.

As with global economic activity in general, trafficking organizations also have benefited from the technological and liberalization trends that have fueled the development of an increasingly open and vibrant global economy. The dramatic rise in international trade, facilitated by the development of a robust transportation infrastructure and the voluntary easing of border controls, have created unparalleled challenges for national customs authorities. In 1991, for instance, the world's top ten ports handled 33.6 million containers. If just two dozen of these containers were filled with cocaine, the world's cocaine habit could be satisfied for one year. Likewise, the deregulation of financial markets and the privatization revolution in the post-communist and developing worlds are overwhelming the abilities of government regulators to police commercial activities within, across, and beyond their borders. The daily turnover of foreign exchange markets is close to \$1 trillion. Annual international capital flows account for about 70 times the value of world trade. In light of these developments, identifying good money from bad money once it has gain access to the legitimate financial markets is worse then searching for the proverbial needle in the haystack.

Implications for DEA, the Justice Department, and the Coast Guard

Law enforcement alone especially on a national level is clearly not the answer to either the domestic or international dimensions of the drug issue. A global problem so closely connected to political, economic, and social trends in the international system requires a comprehensive and multifaceted global response. Nonetheless, the expertise and capabilities of the Drug Enforcement Administration, the Justice Department, and the Coast Guard can make an important contribution to developing such a global response to the scourge of illicit drugs.

First, there is tremendous ignorance among many foreign governments about the nature of the threat. For many, the challenge of drugs and drug trafficking are new problems for which they have no indigenous experience or expertise. Through its overseas liaison offices, DEA and Coast Guard officials can play an extremely helpful role in educating their foreign counterparts. Similarly, through its international police training programs, the Justice Department has a real opportunity to get the message out to a new generation of law enforcement officers in post-communist and developing countries.

Second, there are always new things to learn that requires an overseas presence. The U.S. drug markets are generally at the end of a chain that starts in remote regions of the world. Success at disrupting these distribution networks here often requires that we be informed of activities far away from our national borders. Law enforcement liaison officers are able to work with host governments to gain this kind of information. As I stated at the outset, new drugs and use patterns often have their origins in other societies. By being present in those societies, we can receive useful early warning indicators that can help us develop prevention strategies here in the United States before the use of these drugs reach epidemic proportions. Finally, we can learn of novel new approaches that governments are taking to try to build a common data base, to improve intelligence sharing, and to ensure better coordination among customs and police services. The recently created EUROPOL, for instance, is an innovative approach to improve support for and coordination among the national police services of the member nations in response to transnational crime. Likewise, the INTERPOL Communications Channel is an outstanding example of how police forces can tap the power of modern information-age technology to obtain real time information on international criminal activity without being confounded by the traditional lethargic diplomatic channels.

Third, drug traffickers routinely exploit the gaps within or conflicts among vastly differing national legal frameworks. Sovereign prerogatives generally serve more as a barrier to international law enforcement cooperation than as a barrier to international crime. Initiatives by the Justice Department and those funded by the State Department to assist governments--particularly those of post-communist states and developing countries--in creating efficient and democratic criminal justice systems can play an enormously important role by advancing norms and procedures that are in keeping with our own and international standards of justice. The result is to improve the chances from the outset that drug traffickers will face a common drug control front, not a divided and haphazard one.

Fourth, an active overseas presence by Justice, DEA, and the Coast Guard will provide tangible evidence to U.S. friends and allies that we are not leaving them to their own devices to confront the vexing challenge of drugs. Afterall, it was the massive American appetite for illicit drugs that spawned the creation of the sophisticated modern trafficking organizations and it was U.S. leadership that has been largely responsible for developing the current global prohibitionary regime. To turn our backs on the world would be an abrogation of responsibility at a time when the global community so clearly requires someone to take the lead.

Unfortunately, unless Congress mandates otherwise, overseas programs within these agencies will likely be the first victim of the shift now underway to move scarce resources from supply-reduction programs to demand-reduction programs. DEA, Justice, and the Coast Guard will retreat to core domestic missions as a knee-jerk response to budgetary cutbacks. Further, they are likely to interpret a cutback in interdiction as a message that international programs in general have fallen out of favor. In light of the drug trends in the 1990s and the implications that I have outlined today, I

believe such an interpretation would be inimical to the national interest. While scaling back on resources dedicated exclusively to drug interdiction is appropriate, I urge you to encourage and support legislation which would preserve an activist drug control role overseas for DEA, the Justice Department, and the Coast Guard.

Mr. CONDIT. Thank you, Mr. Flynn.

I am going to direct a couple of questions—you have all done very well, and we appreciate it very much—a couple of questions that sort of revolve around your testimony of international concern to Mr. Flynn and Ms. Falco.

You talked about source countries, and you have named those source countries. Is it your opinions that Colombia is now moving into the heroin market and that is going to be something that they pursue aggressively?

Mr. FLYNN. I think the evidence for that is quite substantial now. In fact, a recent DEA lab analysis that tested heroin seized in New York City placed somewhere around 30 percent of all that heroin of Colombian origin. This is a relatively recent development. It is one that is starting to pick up fuel.

It makes a great deal of sense for Colombian drug organizations to get into the heroin trade. They already have the infrastructure. To diversify the product line seems to be a sensible move from a purely business standpoint. There is evidence of growing linkages between these organizations and European criminal organizations where the Colombians swap cocaine for heroin that they can distribute within the United States.

One issue that is important here is that there will likely be a fight for turf involved with this, and this gets to the violence issue that we are facing in our society. Chinese criminal organizations now dominate U.S. heroin markets. If the Colombians muscle in, like they muscled into the cocaine market in the early 1980's by forcing out the Cuban traffickers, we could see a lot of bloodshed.

Mr. CONDIT. Ms. Falco, do you agree with that?

Ms. FALCO. Yes.

Mr. CONDIT. Do either one of you have any suggestions on—I know that this is not simple in terms of a solution, but as a component of a broader solution, what is your recommendation on any diplomatic action this country ought to take in terms of source countries?

For example, if we get to it by the end of this week, and you don't have to make reference to this if you don't want, but we are going to talk about foreign aid. I know you mentioned Burma. They don't get foreign aid, but we do have some countries in the foreign aid bill that do. Is there any connection to any of this? Is there any diplomatic action we ought to be taking holding these people a little more accountable for this kind of activity?

Ms. FALCO. Absolutely. I have always believed that our concerns about drug control should be at the top of our diplomatic agenda. The unfortunate reality is that many of the major producers in the world don't have very good relations with us, and many others don't get any other foreign aid. In fact, we don't have any real diplomatic levers.

The certification process which the Congress imposed on the State Department's foreign aid program many years ago, has been in many ways a charade. We tend to decertify only those countries with whom we don't have relations anyway—like Iraq and Iran. So the really hard question is what we can do creatively given very few options.

Mr. CONDIT. Do you have any creative suggestions?

Ms. FALCO. I think foreign aid can be in some instances helpful. The Colombian eradication program against heroin is a very interesting local exercise that might help the Colombian Government get control over a situation before it really burgeons totally out of control. Peter Reuter has some interesting comments on how that affects price structure.

The bottom line here is this is not going to help the cocaine situation on the streets of our cities, but I think in a diplomatic context it can be a very important tool.

Mr. CONDIT. Yes. Consumption is one thing.

Ms. FALCO. Right.

Mr. CONDIT. Mr. Flynn, do you have any thoughts on this?

Mr. FLYNN. I might just add on this.

The reality is that the production of drugs has increasingly gravitated to areas where there are no governmental institutions effectively functioning. Afghanistan is an example. The Bolivian Government to a large extent does not have much of a presence beyond the capital city. The Peruvian Government's long battle with the Sendero Luminoso has left it in poor position to exercise much in the way of control over the Upper Huallaga Valley.

So the fact is, even when governments are willing, they are generally unable. This is clearly the case as well in Central American republics where we see rising drug production and trafficking.

Unilateral efforts to bring pressure on drug producing countries through foreign aid are likely to prove discouraging. But there are opportunities that can be pursued through regional and international organizations.

Take the case of Burma, for example. The United States does not have formal diplomatic relations with Burma, which obviously makes it very difficult for us to influence the Burmese Government. Yet the U.N. Drug Control Programme was able to set up a joint agreement between the Chinese, Laotian, Thai, and Burmese Governments to improve enforcement within the golden triangle. The fact that these four countries would even talk to one another is amazing.

Clearly, the United States couldn't initiate that sort of dialog. Sometimes regional and international organizations can. This is one of the areas that we tend to overlook. We should be looking to engage new allies in a concerted effort to create greater incentives for governments to permit drug production within their territory.

Mr. CONDIT. Mr. Kleiman, did you have something to add to that?

Mr. KLEIMAN. Just two things on that because I think that some of the implications of what Captain Flynn and Ms. Falco said need to be emphasized. One is, the collapse of heroin prices in the United States has occurred largely at levels of the market below the wholesale. The price of a kilogram of heroin in New York City has gone from \$250,000 in 1981 to about \$150,000 today. The price of a milligram of heroin delivered to an addict has gone from \$2.50 to 50 cents. So the price collapse has not been in the international market. The glut of heroin around the world—and there certainly is one—has had only a modest impact on the United States. The collapse of prices has been a shrinking of wholesale and retail margins within the United States.

In terms of gross supply, I haven't done the arithmetic recently. The last time I did it, the United States was consuming about 4 percent of the world's opium in the form of heroin. We are not a major player, and therefore it is very implausible that changes in the world poppy production system are going to matter to us.

The Colombian entry into the U.S. market is important, but what is important about it is that Colombian organizations have distribution networks down to the streets in the United States. If those distribution networks start to carry heroin, we are in big trouble. It doesn't matter whether the poppies that make the heroin that they carry were grown in Colombia or in Burma.

Mr. CONDIT. Yes, sir?

Mr. REUTER. There are two countries which clearly have undertaken sustained efforts against drug production that are major exporters to the United States; Mexico and Colombia. Both of them have primarily undertaken those efforts for domestic reasons; in the case of Colombia, because of the violence that threatened the stability of the state. In the case of Mexico, I think it was partly concerns about national sovereignty and "Colombianization," as they see it, of the cocaine trade.

Where the efforts have relied primarily on U.S. funding, as for example in Peru and Bolivia, it is very hard to get the source country government to take the issue seriously for its own purposes. The issue is less aid than it is motivation of those governments to see that this is in their own interests.

Mr. CONDIT. Let me ask, and once again I don't want to oversimplify this at all, but it seems to me—I don't know if I am getting a different message here from different members of the panel here, but the feeling is that heroin has the potential of being the drug of the nineties, and the reason for that from a lay point of view up here is, in the past there was a great hesitation, I believe, among Americans to shoot up with something—take a needle and shoot up; we have a fear of needles. Now it is becoming apparent that you can snort it, smoke it, what have you. So to me you have got more of it out there, you have got more customers, so you can charge less and make it more available. That is, you know, maybe potentially the reason why the price is lower.

If there is a difference of opinion about this, somebody speak up when I have finished talking here. But do we agree, the potential of heroin—that it could become the drug of the nineties?

You know, we went through a heroin phase a number of years ago, and it was among sort of a subculture, I take it, and now, if you kind of mainstream it, snort it, smoke it, it is opened up to everyone else.

Ms. FALCO. Mr. Chairman, we should also remember that in the 1970's there was a very serious epidemic of heroin use among service personnel in Vietnam where heroin was also very cheap, very pure, and widely smoked and snorted. A lot of that was a function of availability as well as the other reasons about being in Southeast Asia at that particular time in history.

Followup studies on those addicts that came back show that relatively small numbers of them remained involved in the heroin culture when it was both unavailable and associated with needles.

We heard earlier Dr. Kleber say in some cities women are now in the majority of crack users. One of the reasons crack is such an attractive drug for women is that it produces enormously powerful highs without the disfigurement and fear of needles. I think that we would see the same kind of potential for heroin.

Mr. CONDIT. Does anyone else disagree?

Dr. KLEBER. No, but I would add a cautionary note. While I believe the potential is there, I would want to stress the point that I made earlier, that you have to overcome the stigma of heroin being basically a dirty drug of the underclass. If it overcomes that stigma and is seen as a chic drug, we are all in big trouble. If it keeps that stigma, there will be a rise, but it is not going to be of epidemic proportions.

Mr. CONDIT. Well, you know, and, again, I am not an expert, I am a layperson, but in California it seems to me in past years crack was not—no disrespect intended, but it was called the trailer park drug. It has become the chic thing to do in California. I mean is that the kind of thing you are talking about? It is accepted?

Dr. KLEBER. Yes. If it gets accepted among the trend setters, the people who hit the newspapers, the people who influence opinion, then we have a serious problem. That was the cocaine chic, the glamorization that caused us all so many problems.

Mr. CONDIT. Which brings me to a point that—anyone can respond to this, but I will ask Mr. Kleiman.

In California we are facing a tremendous crisis with meth labs. We have three times as many as any place in the country. Do you have any suggestions on how we address that problem?

Mr. KLEIMAN. My colleagues will testify that I am rarely short of suggestions, but in this case I am afraid I am going to have to disappoint you.

My understanding is that the recent resurgence in methamphetamine production is a bounceback from the suppression that was achieved when one of the key intermediates, P2P, was scheduled. There was a period when methamphetamine was made from a very complicated chemical called P2P. When that was scheduled and became at least quite expensive, if not unavailable, production was suppressed. Then people figured out how to make it from ephedrine, and we have had a resurgence of production in the ephedrine form, which tends to lead to a higher purity methamphetamine. That is what led to the spread of methamphetamine smoking; ice.

Now the ephedrine has been subjected to slowly tightening regulation. There was a giant loophole for ephedrine fills, and people were buying them by the thousands.

I am a little skeptical that we can make long-term progress. Synthetic organic chemistry is a wonderful thing, and the drug markets are strange and powerful things. One of the consequences of the increasingly aggressive control of ephedrine has been shortages of methylenedioxy-methamphetamine, MDMA, in California, and there is at least one study that shows that among these kids who go to "rave" parties, the unavailability of MDMA has led to increasing use of methamphetamine as a cheaper and more available substitute.

So there is a very complicated game to be played here about which of those chemicals we want to make most unavailable given

the phenomenon of interdrug substitution. But if somebody has got a good idea about what to do about the meth labs, I haven't heard it. It is unfortunately not complicated chemistry, not capital intensive. A meth lab can consist of a stove, a washer, dryer, and microwave oven. The prospects for keeping people from getting methamphetamine if they want it are relatively poor.

Then the question is, are there things to be done on the demand side to make methamphetamine perceived as risky and unfashionable?

It may be the case that the nature of drug education in the schools and in the media which treat all illicit drugs as if they were a single entity may be doing us a disservice here, that once people no longer believe that marijuana will make your head fall off, they then are prepared to disbelieve warnings about methamphetamine, about cocaine, about heroin, I just don't know what to do about that, but Herb does.

Dr. KLEBER. I have to take issue with my colleague here in that it has probably been 20 years since drug education was saying marijuana was going to make your head fall off. Drug education in the nineties—in the eighties and nineties, in fact, has gotten very sophisticated. The scare tactics that were used in the seventies aren't used. It is a much more intelligent approach. Mathea Falco pointed that out in her book that there are many good drug education programs in our schools. We do need to educate our youngsters about the dangers of various drugs.

But I think the point that Mark Kleiman himself made, often they don't know what they are buying, so education cannot be as effective. In terms of MDMA, for example, on the east coast it isn't methamphetamine being substituted for it but much of the MDMA is LSD. MDMA goes for \$20 or \$25 a dose and LSD goes for about \$3, so that by selling MDMA as LSD you make a substantial profit.

So we don't have as much methamphetamine on the east coast but our own equally dangerous forms of substitution.

Mr. CONDIT. I have one additional question, and then I am going to turn to my colleague who has worked on this issue for a long time.

Dr. Kleber, is the problem of border control one of interagency coordination, or is it the lack of resources, or is it just overwhelming? And when you respond to that, what types of drugs are coming over the border?

Dr. KLEBER. Like Mr. Kleiman, I am usually not without opinions, but I have to say what goes on across borders was not my primary area of expertise when I was the deputy at ONDCP. Certainly however, interagency rivalry was one of the things that I was always very aware of and was a problem between FBI and DEA, between DEA and Customs or Coast Guard.

In fact, our first year there, we talked about giving people incentives and grading them in terms of how well they had done their job, by creating a new category of how well they had cooperated with other agencies. That didn't get very far, but I think it had some merit in terms of telling people you could get promoted if you worked with a fellow agency and if they made the seizure, that was OK, that came out on your record too. But I think it is partly the nature of the beast.

I would certainly echo what was said earlier by Dr. Reuter, that DEA is the single most important agency in terms of certain kinds of interdiction. I am delighted they were not combined with FBI. It is the only agency where we can really monitor their budget and say it is all going toward drugs. They are the only law enforcement agency where drugs are the primary concern and are fully dedicated to that issue. At times an issue we have very inadequate information on what was really going on with Coast Guard, Customs, or the Pentagon in terms of how much was really antidrug activity and how much was business as usual that was being scored as drugs.

So on that note in terms of what is really coming over the border and all that, I leave that to—

Mr. CONDIT. Does anyone want to respond to that, quickly?

Mr. FLYNN. Just quickly on that, there is no question that the amount of trade that we have makes this a very, very difficult problem. Illicit drugs increasingly move in maritime containers. The port of Newark last year received about 1.9 million containers. There are 75 Customs people with some National Guard support that are responsible for monitoring this tremendous flow of imports. They can inspect only between 13 to 15 a day of that 1.9 million. Newark is not unique in this regard. The top 10 ports in the world handled 33.6 million containers in 1992, so the volume is tremendous.

Mr. CONDIT. What kind of drugs are moving through?

Mr. FLYNN. Primarily heroin and cocaine. To a lesser extent, marijuana, hashish, and synthetic drugs such as methamphetamine or ice.

But, again, the sophisticated organizations have the ability to move into the legitimate areas which we don't inspect. What we tend to target is the moms and pops. We tend to target people who we can catch, such as the illegal immigrant running across our borders.

And here's another example. I was down in El Paso, TX, along the border in December. At the busiest time of the day, you have a Customs agent standing in each of eight lanes. They are only able to spend 1 minute inspecting each tractor trailer. As vehicle traffic grows as a result of NAFTA these agents may be forced to complete these preliminary inspections in as little as 10 seconds if they are not forced to abandon them altogether.

Mr. REUTER. The limitations of interdictions really are inherent limitations. One could no doubt make it more efficient, but there is no reason to think that that would make an observable difference in any indicator of drug availability that we care about.

It is just extraordinarily difficult to raise the price of drugs when there are \$100,000 on the street by improving our yield at catching \$10,000 a kilo drugs.

Mr. CONDIT. So you feel like if we stop it at one source, it just pops up someplace else if there is a demand?

Mr. REUTER. Yes. I mean essentially interdiction is just a tariff, and we can raise that tariff some. That's what we did with marijuana. Marijuana is the success story of interdiction. The low-cost producer is Colombia, where it sells at the farm gate for one-tenth of what it sells for in Mexico. We get almost all our imported mari-

juana from Mexico, and we now have a large domestic industry. Interdiction has been a successful protection program and that is not a trivial achievement. The cost of marijuana is a lot higher than it would be if we were able to get it in fairly easily from Colombia.

Cocaine and heroin are very high value per unit weight or volume traffic, and the technology to make for effective interdiction simply is not available if we want open borders.

Mr. CONDIT. I appreciate your answers to my questions, and I have got other questions, but I want Mr. McCandless, who has been extremely involved in this issue for a number of years, to have an opportunity to ask whatever questions or comments he wants to make.

Mr. MCCANDLESS. Thank you, Mr. Chairman.

The title of this hearing is "Emerging Trends in U.S. Drug Use," and I think we need to kind of build a foundation. We have got a lot of horsepower, brain power, out there sitting in front of us, and I would like to utilize some of it.

A number of very prominent people in our society have proposed legalizing drugs to take the profit out of it.

Let's start with you, Dr. Kleber. If you agree, fine. If you don't, would you tell us why?

Dr. KLEBER. I just came from the American psychiatric meetings where, in fact, I gave a talk on why legalization would be a disaster.

Mr. MCCANDLESS. Could you give us the Reader's Digest version?

Dr. KLEBER. I will give you a 1-minute version.

We have over 50 million nicotine addicts, we have roughly 18 million alcohol addicts and problem drinkers, we have about 2 million cocaine addicts and less than 1 million heroin addicts. Anyone who has worked with these drugs will tell you that cocaine is much more addicting than alcohol.

If you make cocaine legal in the same way as alcohol and tobacco, which some of the legalizers have proposed, a number of sophisticated analysts, and I agree with them, suggest that the number of addicts would move to somewhere between alcohol and nicotine, or about 20 million addicts. We would not see a decrease in crime.

The only kind of crime you would see a decrease in is the interdealer warfare that has been described, but you would see sharp increases in what I call drug related or basically alcohol kind of crime. That is, think of everything that alcohol does that made Mark Kleiman say, we have got to focus on this most dangerous drug—well, it's legal, and if you make cocaine available in the same way, the domestic violence, the automobile accidents, the child abuse, the irritability, the paranoia will make the dangers of alcohol fade by comparison, so that I think it would be extraordinarily demoralizing; it would be destabilizing to a civil society.

Some of the advocates of legalization like to point to the Netherlands, which really hasn't legalized any of these drugs. It has simply made personal possession of marijuana more freely available. They neglect to talk about Italy. Italy has decriminalized possession of heroin for personal use and now has, I believe, the highest heroin addiction rate and the highest heroin overdose rate in West-

ern Europe. When you make these very dangerous drugs readily available, you see sharp rises in use. That use leads inevitably to increased crime rather than decreased crime.

Mr. MCCANDLESS. Mr. Kleiman, Dr. Reuter, do you have anything you would like to build on top of that? Maybe you are for it?

Mr. KLEIMAN. I would agree with Dr. Kleber that no intoxicating, addictive substance ought to be made as freely available as alcohol now is, including alcohol. We ought to start thinking seriously about whether the legalization of alcohol has gone too far. In particular, why should someone who, for example, drinks and drives, lose his driving license but keep his drinking license? Should we make it the rule that somebody who seriously criminally misbehaves under the influence of alcohol is no longer eligible to purchase, and put responsibility on the sellers of alcohol to enforce that ban just as there is a responsibility on them not to sell it to adolescents?

The best case against legalizing any of the currently illicit drugs is the catastrophe that we have had since we have legalized alcohol. We ought to think about what to do about that.

Mr. REUTER. I am also not a legalization advocate. On the other hand, I disagree with my friend Herb Kleber about how well we can predict the consequences of legalization.

First of all, we do not have to legalize everything. Second, legalization does not have to be handled as we have irresponsibly handled nicotine and alcohol.

Third, we simply don't know how to project the increase in use that would result from some sensible regulation. On the other hand, having spent the last 3 years mostly working on this problem—I don't see any way to narrow down the uncertainty about what would happen if we legalized under any restrictive regime. Cocaine is particularly troubling and given that uncertainty, unfortunately, I think we need to stick with current prohibitions. The issue is less legalization than how fiercely we should enforce those prohibitions.

Ms. FALCO. I also oppose legalization. I would remind all of us that 95 percent of the American people have consistently opposed anything that even looks like legalization in national polls over the last 10 years.

But many of us have come to think that an exclusive law enforcement response to the problems of drug abuse are just simply not going to work. I think and we now are looking at a much more comprehensive approach.

But I don't think legalization is a good idea. I don't think very many people who advocate it, when pressed, have a very clear idea of how they would do it. Where do you draw the line? To whom do you give drugs and under what conditions? Once you get into the details, the debate rapidly begins to degenerate.

Mr. FLYNN. I guess just a final word. I don't think legalization is the answer as well, particularly if we focus on the international dimensions of the problem. There are the problems connected with drug use and the problems connected with drug trade. Legalization would have to resolve both these sets of problems if it were to be considered a viable alternative. To a large extent, of course, where people talk about legalization they mean some form of regulation.

A legalization regime would require the government to regulate who can use drugs, at what purity levels, what kind of drugs, and so on. We would probably tax drugs, both to raise revenue and create disincentives for purchasing them. All these regulations require functioning institutions to make them work, and you have to have institutions that can deal with the public health consequences as well.

For the sake of argument, let us imagine that our institutions were able to turn the drug trade into a legitimate business in the United States. One likely result would be to create incentives for global production and distribution to move into other areas, particularly to developing countries and post-communist countries, where there are virtually no institutions capable of managing a regulatory legalization regime work. So the net result of legalization within the United States would be to leave largely unaffected the burgeoning overseas drug trade and its relationship to ethnic conflict, weapons proliferation, issues of environment, and so forth. So legalization strikes me as a solution that isn't a solution.

Mr. MCCANDLESS. Now, Mr. Chairman, we have them all on record in opposition, right?

Mr. CONDIT. We absolutely do. I will witness to that.

Mr. MCCANDLESS. Shall we pull the trap door?

Let me move to the next step which, to me, is very important. I kind of thought that this was what the answer would be.

The Federal Government has a multitude of plans. Back in 1986, 1987, this committee, the full Committee of Government Operations, took a look at this—Jack Brooks was our chairman at the time—and they said, "We need to coordinate all of this; it is splintered, it is fragmented, we are not focusing," the sum total of which was the Office of National Drug Control Policy was created with Secretary status for the director: Oh, that would be the answer to our problems.

The only problem is that the director has a portfolio, but it doesn't have anything in it in the way of authority in terms of direct line action. The power of persuasion and the ear of the President appears to be the way success will be achieved. Many of us were not too enamored with the way this turned out in terms of the final legislation.

But be that as it may, now that we have decided that we do not want to legalize drugs, we need to concentrate to the maximum degree possible the resources of the U.S. Government, the Federal Government, in moving forward to try to put this thing in some type of a control factor.

I know that Dr. Kleber, that you were former deputy director of this organization, ONDCP, and I am sure that you, Dr. Reuter and Mr. Kleiman, in your transition assignment at Justice Department and DEA, ran across this and had a great deal of discussion. I would like your observations on whether we have the right mix here. Do we have the right formula for the focusing of our Federal activities in this particular department as it is now constituted?

If not, what do we do here in the legislative process to give it more focus, to utilize the overall resources of the United States to a greater degree than we possibly are now?

We have so much duplication going on that a lot of money is being wasted that could be concentrated, and that is my question to you, gentlemen, who have had direct experience in this.

Dr. KLEBER, why don't we start with you?

Dr. KLEBER. I was afraid you would.

Mr. MCCANDLESS. If you think it is inadequate, you think it needs to be revised, you think Congress needs to revisit the subject, give it some teeth, I am interested in your thoughts, because we need to do this in some form of another, or maybe it is fine.

Dr. KLEBER. Well, it clearly isn't fine.

Mr. MCCANDLESS. OK.

Dr. KLEBER. It clearly isn't fine. It is something that Congress needs to revisit, especially since sunset is an issue. To simply renew it without reviewing it would be a major mistake. That is easy to say. It is much more difficult to say what form should the— the change take place.

Mr. MCCANDLESS. Let me interrupt you just a minute.

Dr. KLEBER. Yes, sir.

Mr. MCCANDLESS. There is an underlying thought here that I would share with you. It has a 1-year life cycle currently.

Dr. KLEBER. Yes.

Mr. MCCANDLESS. In the conference committee on the national crime bill, there is a desire on the part of somebody to extend that another 2 years, 3 years, and to put it another way, in serving on that committee, I am interested in your thoughts here.

Dr. KLEBER. I think it definitely needs review. I think in many ways since the days of Bill Bennett where, through sheer force of personality and Presidential support more than the law, a lot was able to get accomplished in terms of agency coordination, getting things done. Once you lost that, the office, in spite of good intentions, has sunk into if not a paper tiger, at least it does not have the kind of power that it needs to have as a true coordinating agency.

It cannot really tell agencies what to do in terms of their budgets. They routinely circumvent—and, by the way, that is not just the supply side, that is also on the demand side. One of my biggest annoyances as deputy for demand was the VA. We regularly increased the money for treatment, and they would tell us by their own surveys that the money we were giving them wasn't going for treatment, that of the \$50 million new money we would give them for treatment, 35 percent would go for drug treatment, 40 percent had nothing to do with drugs, and 30 or 40 percent they weren't quite sure of, and nothing happened from their having said that, and I think that is a disgrace.

It is that kind of lack of ability to enforce even good intentions that I think have to be remedied. If you are going to keep the office, it needs to have a very clear mandate as to its power. If that is given, it should be kept.

The OMB has to understand what that mandate is, and the relationship has to be worked out clearly. Many of the ideas that our office had were totally undercut by Mr. Darman—and that has been spelled out in other places—and the amount of money we wanted was totally undercut as well as how it was to be distributed. If that is going to continue, then you are not going to see the

kind of coordination and ability to achieve what I believe the Government could achieve.

Mr. KLEIMAN. I should start by declaring my conflict of interest. I am affiliated with a company called BOTECH Analysis Corp. which has been since 1991 a contractor to ONDCP, so whatever I say should be appropriately filtered for that.

It seems to me the notion of having a substantial staff office in the White House to manage a major crosscutting issue was a sensible one. The notion of having 150 people in it to micromanage at the agency level was not a sensible one and didn't work.

The notion of using it as a whipping boy whose director would be summoned up here to be beaten around the head and ears about why the drug problem hadn't disappeared this month was an inevitable temptation but I think a very bad one. And I don't know whether Herb will agree with me or not; my sense was that there was a very strong commitment within some of the ONDCP staff to make the numbers look good and that some of the data were—not in their publication form but in their press release form—severely distorted for that purpose, with the result that many of the agencies that produced the data are now extraordinarily reluctant to share it with ONDCP or with ONDCP contractors for fear of similar manipulation. That is a piece of history that needs to be worked through.

I don't think that there is a case for micromanagement of the drug war from the White House. I think Dr. Kleber is right that getting the lines of authority clear, particularly the flow of the budget paperwork clear, so that people in HHS, in the Veterans' Department, in Justice Department, know that their budget fate depends in part on whether they keep ONDCP happy would make a big difference.

My understanding of this year's budget round at the administration level was that ONDCP got pretty much what it wanted, and I think if that continues, Dr. Brown's ability to influence things will be enormously greater than the ability of his predecessor. I have one more note about the power of ONDCP, which goes back to something Dr. Kleber said earlier about the increase in self-reported drug use among high school students. It was not caused by, for example, Dr. Elder's remarks, unless she had magical powers to cause things before she acted on them. The trough in self-reported adolescent drug use happened in 1981. If therefore, Federal policy had nothing to do with it—which I doubt—it must have been Bush administration policy.

Mr. REUTER. When ONDCP was formed, I asked people who had more experience with White House agencies whether there was any precedent for a successful coordinating office in the White House dealing with something that cut across as many agencies as this. Of course OEO was brought up as something that was the poverty "czar"—poverty fighting coordinating agency, and that was thought to have been at best only moderately successful. Moreover OEO had to deal with less variety of agencies.

The need to be able to deal with the Defense Department on one hand and a research institution like NIDA on the other hand, I think, is inherently an extraordinarily complicated task. In the end, budget authority may be all that you can really ask of agency.

Clearly ONDCP has not been a major player with respect to such basic issues as mandatory minimums, which is an important element of drug policy.

The Federal drug budget is very much an accounting fiction. It is not an appropriated budget, but an ex-post estimation by agencies of what they have spent on discharging what they define as the drug functions. There is a serious question whether the figure is anything like \$13 billion and what its balance is between demand and supply control.

If Congress thinks the budget is important, then ONDCP should have both resources and authority to actually do the budget calculations correctly, and committees involved in appropriations should see the drug budget lines within the agencies that they deal with. I gather right now that this is not a common practice.

Mr. McCANDLESS. Ms. Falco, do you have any comments you would like to make?

Ms. FALCO. Nothing to add.

Mr. McCANDLESS. Mr. Flynn.

Mr. FLYNN. I just may make a final point on this. One of the reasons why we have largely overlooked the international dimension of the drug issue is that we allow each agency or bureau that receives Federal moneys to define the problem through their own bureaucratic lenses. Take the National Park Service for instance. It has a piece of the drug budget because U.S. citizens grow marijuana in national parks and forests. The U.S. Park Service therefore sees the drug issue as an issue of domestic cultivation. It is not concerned with what happens overseas. When each agency is left to define the drug issue according to how they are able to respond to it and these definitions, in turn, serve as the basis for budgetary decisions about how limited Federal resources will be allocated, we are apt to find that the sum of the parts simply will not equal the whole. I think the biggest thing we could ask ONDCP or some entity like it to do is to help us step back and understand the problem comprehensively. ONDCP must do more than simply compile all the parts and try and make the result sound like a coherent response. This approach is not working.

I also might criticize the academic community along these lines as well. The drug issue is truly multidisciplinary. It has everything from botany to epidemiology to criminal justice, you name it, and like bureaucrats, academics are often stovepiped. That is, they only study things, and through narrow disciplinary lenses, and again the sum of the parts don't equal the whole.

Academics and policymakers must do a better job in analyzing the drug issue than we have done to date. We need to focus on this challenge as a preliminary to narrow managerial questions of how resources should be allocated among the array of Federal departments, agencies, and bureaus tasked with handling the supply and demand sides of drug control.

Mr. McCANDLESS. I have one more quick one, with your permission, Mr. Chairman.

Mr. CONDIT. Absolutely.

Mr. McCANDLESS. One of you gentlemen touched on this when we talked about Mr. Gatlin's history and the road to recovery, that he had fame and fortune and his Rolex watch to look forward to

as an incentive to accomplish the objective of rehabilitation, and there is an implication there brought about by many conversations, some on the floor of the House, that the drug culture will continue because many of the people who are active users are doing it to escape from reality; that they have nothing to look forward to, that society has dealt them a bad hand, and that you put them in a rehabilitation center, they go through the process, but they come back to the same environment without anything in the way of tools or abilities that they didn't have before they left. Therefore it is the responsibility of government to take that next step and to have programs available to them which will change what it is that supposedly brought them into the circle to begin with.

Your thoughts on that, Dr. Kleber? Are we trying to justify human behavior by saying this, or is there some real reality to this? Do we need to look at this more closely than just a way of saying that is their problem?

Dr. KLEBER. It is both true and false. That is, the majority of people who live in the kind of communities that you have described and who are under those circumstances do not use illicit drugs. That's one of the myths of our time, that most of the people in poor urban areas are using illicit drugs. That's simply not true. We are also aware that many of the people who use illicit drugs are not poor and don't have those kind of problems, so that it is a much more complex situation than simply saying that poverty drives illicit drug use. Poverty clearly is one of a number of factors; it is not the sole factor or, in many cases, the major factor.

Having said that, the converse remains true, however. That is, recovery is much more likely to occur with an individual where there are resources, where that person can see some reason for giving up the drugs. Poverty, racism, unemployment are all unacceptable, but also they are not things that are going to be changed overnight. The rest of government needs to keep working on that.

While they are, there is still much that can be done to rehabilitate individuals that are caught up in drugs even though we can't eliminate overnight poverty, racism, and unemployment. There have been a number of excellent in-prison treatment programs that combine the therapeutic community kind of disciplined treatment with vocational, educational, et cetera, endeavors so that when people leave prison and if there is followup treatment and help with employment afterwards, they can do quite well. I don't believe we need to despair and to say we can't do anything about drugs until we do something about solving all the other problems in society.

Mr. KLEIMAN. I think that is right. It has not been shown to be the case that poverty or social dispossession is a risk factor for trying drugs, whether illicit or licit. It is closer to being true that having resources reduces the risk of becoming a serious long-term problem user, and it is certainly true that having resources and having something to look forward to increases the rate of successful recovery.

But short of solving all the world's problems, it seems to me there are some things that could be done. The best single predictor of success in the legitimate employment market is basic academic skills as measured, for example, by reading scores. That raises the question about whether both drug treatment programs and pro-

grams within the correctional system ought to get more aggressive at promoting those skills.

There is one very good study by Professor Ann Piehl, a colleague of mine at the Kennedy school, that shows in one correctional context that prison literacy programs made a substantial contribution to reduced recidivism. If all the boot camps we are building spent a little more time on reading and writing and a little less time on pushups, they would probably be more effective in giving people, when confronted for the next time, to use or not to use, a better alternative to drug use than they otherwise have.

Mr. McCANDLESS. Ms. Falco.

Ms. FALCO. To put it in perspective, the National Household Survey reminds us again this year that two-thirds of all current illegal drug users are employed and three-quarters are white. When you control for sociodemographic variables, like gender, education, occupation, marital status, there is very little difference in drug use between minorities, particularly African Americans, and whites.

This study—SAMSA has just released this—shows that blacks are 3.9 times more likely than whites to use crack. But once they control for sociodemographic variables, blacks are only about 1.9 times more likely to use crack, which is a nonsignificant difference.

So I think that goes to the deeper point that Mark was making that sometimes reading skills or intellectual muscle might be just as good as physical muscle in turning this problem around.

Mr. McCANDLESS. Mr. Flynn.

Mr. FLYNN. No comment.

Mr. McCANDLESS. Fine.

I want to thank all five of you and appreciate very much your sharing your thoughts with me. If you have any additional thoughts that you feel were neglected or would like to share with me, I assure you, if you want to discuss them with me through correspondence, they will remain confidential.

I am very much dedicated to this subject and have seen the problems both on this side of the border and the other side of the border and in the host countries: The fact that when crack was first introduced in Colombia, it was the residual of the process and therefore is highly concentrated, and you had Colombians jumping out five-story windows because they didn't realize the impact that this had on them, they had been used to the normal stuff.

Thank you. Thank you, Mr. Chairman.

Mr. CONDIT. Thank you, Mr. McCandless.

We have additional questions. Could we mail those to you? And, as Mr. McCandless has said, if you have additional remarks beyond that, we will keep them in confidence and we appreciate your being here. You have been very generous with your time and your words, and we appreciate it very much.

Thank you.

We will take the next panel. If you would please rise, I would swear you in. Please raise your right hand.

[Witnesses sworn.]

Mr. CONDIT. We appreciate you being here this morning, and I know that all of you have been here for the entire hearing, and I appreciate your patience.

We will begin with Mr. Haislip, who is the Deputy Assistant Administrator of the Office of Diversion Control, Drug Enforcement Administration.

Mr. Haislip.

STATEMENT OF GENE R. HAISLIP, DEPUTY ASSISTANT ADMINISTRATOR, OFFICE OF DIVERSION CONTROL, DRUG ENFORCEMENT ADMINISTRATION

Mr. HAISLIP. Thank you, Mr. Chairman. It is certainly a privilege to appear before you and your subcommittee and to be a participant in a very important process that you have begun.

I have listened very closely to the testimony this morning, and I must say I am very impressed with the quality of the remarks that I have heard. Even though I find things to disagree with, I think I found much more that I did, in fact, agree with. Certainly that was the case with your first witness as well as the distinguished panel that you heard.

The drug problem is, of course, the subject to which all of us in DEA are dedicated. When we see strong evidence of congressional interest, it is always a great pleasure to us because we have worked very closely with the Congress on much legislation and many programs, and ultimately this cooperation has been, in my view, to the benefit of progress in the attack on the drug problem.

I would like to say that some of the things that I want to point out are not good news. There are some trends that concern us very much, but I do think it is also true, as Dr. Kleber said, that in the recent past we have seen some considerable improvement, especially in the attitudes of the adolescent and young adult population. This shows that improvement can be obtained if sound policies and programs are pursued and I think that despite the bad news that I have to say, we nevertheless still have some reason for optimism because of what we have seen in the past.

In my remarks I would like to initially attempt to assess the drug problem that we have today and where we stand and what we see, and I want to point out first that in DEA we use a variety of sources of information for that purpose.

Actually, there is no one good source of information that really tells us enough about the problem or gives us an adequate idea, so we use systems that we have developed within DEA, such as our scientific analysis of drug evidence that we seize, and analysis of all of our case and investigative activity. We use these sources a great deal, but we also use the statistical systems and reporting systems of other agencies, and some of these you will be hearing from in other testimony.

I think a particularly good system is the so-called Drug Abuse Warning Network [DAWN] because it deals with emergency room episodes and with coroners' reports; it deals in very large numbers, and statistically that is very useful. I think it is one of the best of the systems to give us a way of comparing what is happening among the various categories of drugs in terms of where abuse is declining or increasing, and how that matches with our efforts.

So without detailing the systems, because it is in my written testimony that I am submitting for the record, suffice it to say that they are all good, they all have limitations, but none of them tells

you a great deal unless you integrate all of that information to draw your conclusions. That is what we do in DEA, and we employ quite a number of people whose task it is primarily to do that for us.

What we see is that indeed there appears to be something in the neighborhood of between 10 and 12 million Americans who are very seriously and clinically involved with some form of drug abuse. But the drug problem we have in the United States, as is true in most or much of the world, is very much a poly drug problem.

We have problems with many drugs of different kinds, and, of course, cocaine has been the one that has concerned us so much. I am speaking now of controlled drugs, although I have feelings very similar to the speakers you heard about tobacco and alcohol, but I am just speaking of the controlled drugs.

Cocaine, of course, is the principal drug that we see in so much of our data and probably accounts for 40 percent of the emergency room mentions for the top 20 controlled substances that we see in the DAWN system, and that figure seems to be reflected by almost every other indicator that we examine as well. Unfortunately there has been something of a rebound in that problem from the earlier decline that we had seen in 1989 and 1990, and I think we have some ideas why that has occurred. One of the more important trends to be concerned with here is the fact that we see at the same time an enormous increase in the cocaine traffic in Europe.

The reason this is important for us, aside from our sympathy for the European population, is because it has the potential for greatly increasing the economic resources of these most powerful, cunning, and vicious cartels in Colombia. We could see their income going from perhaps \$7 or \$8 billion to perhaps closer to \$20 billion if they established that kind of a market there, and with those resources the amount of damage they can do to the United States and, even worse, to Colombia as well as others would be far in excess of anything we have seen so far. So it is really an important concern even though it is happening in some other part of the world.

Perhaps the newest thing that we have seen of real concern to us is the significant—I would emphasize significant—rise in the heroin problem. Again, just referencing the DAWN figures, we see that the problems reported by that system have increased by about 46 percent in a single year. Now, again, that seems to match other information that we have, especially with regard to the price and the purity of the drug that we see on the street.

It used to be that it was customary to see in New York and on the east coast heroin being sold in a purity of about 6 to 10 percent, and now it is quite common to see parties of 30 and 40 percent, and we have seen it as high as 70 percent on the street. In fact, DAWN estimated drug abuse episodes for heroin in Newark, San Francisco, and Seattle exceed those for cocaine, and that is a significant change.

Now again, another important factor has been the establishment of the heroin traffic and industry in Colombia. This is of grave significance because if the cartels succeed in organizing that traffic and making it an item of their deadly inventory as they have cocaine, then again we would see an enormous increase in the problem, and an increase in the availability of heroin, with tremendous

damage to our country and with the kind of damage to the Colombian society that is difficult to contemplate.

This is a serious threat that we need to give attention to. The United States is not alone in this. All of these problems that I am mentioning we see in other parts of the world. In fact, I think it is true that the drug problem in general is probably growing faster now in many other countries than it is in the United States.

It has been mentioned that marijuana also appears to have increased, and I think this is a particular concern because it is usually the first illicit drug that abusers become involved with, resulting in a pattern of drug abuse which becomes more and more vicious as it proceeds.

I would like to mention specifically—and I know it is of concern to you—a homegrown problem we have, which is the illegal manufacture of drugs right here in the United States. The principal one is methamphetamine or what is called “speed.” Now we have sought and obtained from the Congress some very important legislation to control the chemicals for the manufacture of that drug, and we have had very good results. In California particularly, however, we see other new problems occurring in this area.

Basically what is happening, to state it simply, is that now the chemicals which are so difficult to obtain in the United States are being smuggled in from Mexico, and the Mexican traffickers have largely taken over this market. So to deal with this very domestic problem of illicit manufacture, we must deal with the foreign source problem in Mexico. We have some ideas about doing so, and we have actually begun to implement them.

Another one of these domestically manufactured illegal drugs is PCP. This is a drug that caused quite a bit of havoc a number of years ago, and the fact that its abuse seems to be increasing alarmingly is a real concern. Emergency room reports for PCP are up 45 percent nationwide, and here in Washington, according to a hotline service, calls are up by about 155 percent. This is a drug particularly associated with violence, not only by the abusers but also by the manufacturers. It is usually the black gangs on the west coast, the Crips and Bloods, and they do engage in a great deal of violence in their activities.

The newest drug that we are dealing with has been mentioned, and this is methcathinone or CAT. We have had quite a bit of help from a number of Members of Congress, including a member of your subcommittee, Congressman Stupak, and we have a new law which we think will help us a great deal. I have to say at this point we are still in the process of trying to get it implemented, and so we have not yet seen the concrete results that we expect to get.

LSD has also been mentioned. At the moment the situation is stable, but it is a serious problem that does concern us.

Mr. Chairman, another part of the drug problem that is seldom mentioned that a lot of people don't focus on and don't even know about comes from the so-called legitimate drugs which we produce here in the United States for very legitimate and indeed very important medical purposes. These drugs are important in medicine, but they are also very similar pharmacologically to the illicit drugs. I refer to the narcotics such as hydromorphone [Dilaudid] which is a very powerful drug—more powerful than heroin actually, a drug

very important for the treatment of terminal cancer and other severe pain but a drug that is also very much desired by the addict population and therefore is diverted from corrupt individuals into the illicit traffic.

This is true of other narcotics and stimulants that are legally available, and one of the most troublesome, in my view, is the drug methadone. It is used in narcotic treatment programs to treat heroin addicts, but it seems also to be associated with quite a number of overdose deaths. Now actually I don't think that this is a problem in well run treatment programs, but it appears that these programs are now spreading primarily for profit, offering very scant rehabilitative services, and we find that they often are run in a very shoddy fashion.

Some of these we are trying to deal with from an enforcement perspective, but you should know that there are only about 2,000 or 2,400 kilograms of this drug, which is a legitimate drug—a legitimate drug—available in our country on a yearly basis. Yet when we get reports from coronors' offices, we get one report for methadone for every eight reports we get for heroin nationwide, yet heroin is entirely illicit, where methadone is entirely legitimate, and if we look at the New York area where so many of these programs operate, one coroner's report for methadone is received for every four of heroin.

I have appended to my testimony a recent letter to the editor that appeared in the British periodical *Lancet* that indicates that the experience in the United Kingdom is very similar. I think this deserves attention, and again I would emphasize that we see methadone being diverted to the illicit traffic primarily from those programs that are operated in a shoddy fashion. We believe that is where the big problem lies.

I would say also that the problem of tranquilizers is back with us. This is the problem of the fifties we saw so much and which was publicized in "The Valley of the Dolls." All of the severe problems of addiction to Valium that were documented in the literature, in research and also in the popular media, we see this again resurging. In fact, more than half of the emergency room admissions involving legitimate drugs actually involve these so-called tranquilizers or benzodiazepines, such as alprazolam known as Xanax, diazepam, which is of course Valium; and a new one for which emergency room reports are increasing very rapidly, clonazepam, which is called Klonopin in the legitimate market. It is a feature of the drug problem that needs to be understood, because it is a rather significant part.

Mr. Chairman, as we look at the data over the years, we do see a considerable fluctuation in our drug problems, and usually I don't think it is very difficult to identify what causes those fluctuations. Whenever there is a great increase in a particular problem, it has always been preceded by favorable attention in the media and usually by a great increase in the supply to respond to the demand generated by that kind of favorable attention.

We saw that in the case of LSD, we saw it in the case of marijuana, we certainly saw it in the case of cocaine, and it should be remembered that we had many so-called respectable authorities, including government officials, scholars, and many others who

made statements that encouraged this kind of demand. Their statements indicate that the drugs were not always dangerous, or could sometimes be used safely, or perhaps could indeed enhance one's life-style. This is what we generally have seen behind so many of the drug problem increases that we have had, and is, I think, the major ingredient of the cocaine epidemic that we have experienced.

On the other hand, when we see decreases, as we also have done usually we can equate that very clearly to a bad press image resulting from the mayhem that the abuse of the drug has created and also to effective enforcement action. Again I would mention LSD, where, because of the reports of "bad trips" that problem was really reduced by adverse media attention. The same thing we saw for a period of time with regard to cocaine, and certainly the problem of Quaaludes which was once as big as the heroin problem. The Quaalude problem was completely eliminated through enforcement action. These are some examples of what we have seen, and I would say these drug problems are never a mystery, it is just a question of trying to understand them and elucidate the facts which explain what happened and why.

In this regard, I think it is unfortunate that today there is indeed once again so much media attention to the question of legalization and the consequences thereof, and I think the witnesses before you today have made a very clear statement on that. I would like to think that that would put the issue to rest.

I know that Dr. Lee Brown just yesterday made a very strong statement about the administration's views on legalization. We in DEA have studied this issue and certainly feel strongly that that would be a disaster. Unfortunately, the continued debate on it, which has only recently reoccurred I believe has had the effect of encouraging many people and many interest groups to think that there will be a change in public policy, that this is the time to agitate for change, and that may be one of the factors that is driving some of the increases in the drug problem that we see.

I think that many important things have been said to you this morning about which we in drug enforcement have very strong feelings. I am not going to go further with my statement at this time, but I am more than pleased to respond to any questions you may have on any of the things that have been said today. There is nothing here that is not of vital interest to the Drug Enforcement Administration and in which we do not take a strong interest.

Thank you, sir.

[The prepared statement of Mr. Haislip follows:]

Statement

of

Gene R. Haislip
Director, Office of Diversion Control
The Drug Enforcement Administration
United States Department of Justice

for

The Subcommittee on Information, Justice, Transportation
and Agriculture
U.S. House of Representatives

Concerning

Illegal Drug Use in the United States

May 25, 1994

Chairman Condit and Members of the Subcommittee: I am very pleased to appear before you today to represent the Drug Enforcement Administration (DEA). I hope that my participation will be of value in assisting your present and future consideration of measures to combat the illicit drug problem. This is the cause to which the men and women of DEA have dedicated themselves with vigor and persistence throughout the United States and in 49 countries around the world.

To successfully attack a problem, we must first understand it, and understanding the drug problem is almost as difficult as combatting it. Therefore, it is reasonable to begin with an assessment of the status of the problem and the people it affects. These are the questions which you have raised for this hearing, and I will direct my remarks principally to addressing these concerns.

There are a variety of sources of information which DEA uses to assess the trends in drug abuse and illicit trafficking in order to adapt our efforts and strategies. While each of these sources provides valuable data, each has its limitations. For this reason, they must be considered together, one in relation to the other, before any valid conclusions can be reached. I would like to mention the principal sources briefly before giving DEA's views as to what this information collectively tells us.

STRIDE (System to Retrieve Information from Drug Evidence, analysis of the DEA forensic laboratories) -- This data base consists of the scientific analyses of evidence samples acquired primarily as a result of DEA investigations. It is highly accurate and is used for many

investigational and strategic purposes. The data does not, however, necessarily reflect what is happening in the community since these drug samples are largely the result of enforcement priorities suitable to DEA, which must be highly selective in its choice of targets.

Domestic Monitor Program (DMP) -- This is a system which DEA operates to collect street-level intelligence on the purity of heroin sold in 19 U.S. cities and San Juan, Puerto Rico.

DAWN (Drug Abuse Warning Network) -- This is a comprehensive data system created by DEA, and now operated by NIDA, to collect data regarding drug-related hospital emergency room episodes and analyses from medical examiners. Although it covers only that portion of the drug abusing population seeking emergency room treatment, together with drug-related deaths, it is generally indicative of abusing patterns in the general population.

Other NIDA Surveys and Working Groups

- ***National Household Survey on Drug Abuse (NHSDA)*** -- This survey seeks to measure the prevalence of drug abuse in the general population based on responses to questionnaires.
- ***National High School Senior Survey*** -- Also known as the *Monitoring the Future Study*, this survey seeks to measure the prevalence of drug abuse among 8th, 10th and 12th graders based on responses to questionnaires.

- *Community Epidemiology Work Group Meeting (CEWG)* -- A biannual meeting of representatives from 20 major U.S. cities, foreign countries, and federal agencies who report on the most current trends in drug abuse.

Special Reports and Studies:

- *Center for Substance Abuse Research (CESAR)* -- A program run by the University of Maryland which collects data on drug abuse especially in the Washington, D.C. and surrounding areas.
- *Drug Use Forecasting (DUF)* -- This program collects data from urinalysis and self-reports from booked arrestees in 23 major U.S. cities. Testing is done for 10 drugs including cocaine, opiates and marijuana.
- Published scientific and epidemiological studies available in books and publications of scholarly reputation.
- Investigations, seizures and special intelligence probes.

A great body of information having a high degree of specificity and accuracy emerges as a result of the law enforcement activities of DEA and other Federal, state, local and foreign police services. This information results from undercover negotiations, wire intercepts, arrests, seizures, informants, seized records and special studies of specific drug and trafficking situations.

DEA not only collects and creates this information, but employs numbers of personnel to bring the information together and make sense of it. I believe that the picture which emerges is a fairly accurate one, and at this point, I would like to address some of the more important trends which we see emerging.

The NIDA surveys, which I am sure will be commented upon fully by their representatives here today, give us a general idea of the prevalence of drug abuse in the general population. The 1992 data shows current (in the last month) users of illicit drugs to be between 10.5 and 12.3 million. Similarly, the high school survey found in 1993 that almost one out of two (43 percent) of 12th graders had used an illicit drug by the time they were seniors. This type of abuse may lead to more serious involvement with drugs which is likely to result in the typical problems of drug dependence.

The *DAWN* system is probably the best system in terms of giving us some indication of the comparative frequency of injuries caused by drug abuse, and we find that it generally accords with our law enforcement experience. Thus we see that nationally, for the first six months of

1993, cocaine accounts for about 38 percent of the mentions for the top 20 controlled substances. Similarly, heroin now represents about 19 percent of the mentions, and the trend from the fourth quarter of 1990 to the second quarter of 1993 shows an increase of 111 percent. Marijuana mentions have also increased by about 17 percent in comparing the first six months of 1993 with the same period for 1992. Marijuana accounts for about 7 percent of the mentions for the top 20 controlled substances. This is particularly alarming as marijuana is considered by many to be a gateway drug that usually initiates a pattern of drug abuse.

One of the most serious concerns we have is the recent upsurge in the illicit traffic of heroin. Heroin use is also increasing; the *DAWN* statistics show nationally that there has been a sharp increase in the consequences of heroin use in three major metropolitan areas, Newark, San Francisco, and Seattle, where heroin continues to be the most reported drug -- exceeding even cocaine. Moreover, analysis of data from the *Domestic Monitor Program* shows street-level purity continuing to rise. This can be attributed to some degree to the influx of South American heroin, primarily from Colombia. The growing traffic in heroin from Colombia and the cultivation of the opium poppy in that country is an ominous development. The current situation with Colombian heroin is what the Colombian cocaine traffic looked like in the late 1970's. Such a development could inflict enormous damage on Colombia and the U.S. To address this concern, the Government of Colombia, beginning in 1991, mounted an aggressive campaign of aerial eradication of opium poppy. Last year, the Government of Colombia eradicated roughly 10,000 hectares of opium, or one-third of the total estimated cultivation.

As I mentioned earlier, there are other equally disturbing problems. The level of traffic in cocaine seems to have rebounded from its earlier decline in 1990, and once again the number of *DAWN* estimated episodes has risen to levels at or above the peak in 1989. At the same time, we are seeing a great increase in the cocaine traffic in both Western and Eastern Europe. This serves not only to threaten the populations of those countries, but increases the financial base of the Colombian traffickers which enables them to engage in violence, corruption, and new trafficking ventures of all kinds.

In addition, our forensic and investigative information continues to document the serious nature of our own domestic illicit drug manufacturing problem. *DAWN* data also shows that mentions for clandestinely manufactured drugs are at about the same level as those for marijuana. Methamphetamine (Speed) has shown recent increases in abuse on the West coast. This may be partially attributed to the increasing use of methamphetamine by Hispanics and to the new prominence of Mexican traffickers who smuggle chemicals for its illicit production into the United States from Mexico, where controls on these chemicals are lacking. Abuse of PCP, an hallucinogen much associated with violence, has increased sharply in some parts of the country, especially in Los Angeles, New York, and here in the District of Columbia. For example the Washington Area Council on Alcoholism and Drug Abuse (WACADA) reports a 155 percent increase in hotline calls regarding PCP last year. This drug is manufactured principally on the West coast by the violent, black street gangs such as the Crips and Bloods. Concerning LSD, the trend in abuse has shown little or no change over the past four and one-half years, although there have been some recent reports of possible increases in use. The

dominant factor for LSD continues to be the age of the abusers. *DAWN* data for 1992 shows that 57 percent of the estimated episodes involve individuals 6 - 19 years of age. Finally, every year we are faced with some new "designer drug" which requires unanticipated law enforcement responses. Now we see the slow spread of the drug methcathinone, known as "Cat," from its origins in northern Michigan. This is a powerful stimulant much like methamphetamine or cocaine which can be manufactured with relative ease. However, thanks to the action of Congress in passing our Domestic Chemical Diversion Control Act in the fall of last year, we now have some new tools with which to attack this problem.

Many people are unaware of the fact that legitimate prescription drugs, which are in every way as potent as their illicit counterparts, account for about one third of all the drug abuse mentions in the *DAWN* system. These are powerful narcotics such as hydromorphone (Dilaudid), methadone, and oxycodone (Percodan), stimulants, depressants and tranquilizers. In fact, the legal narcotic methadone, which is used to maintain heroin addicts in methadone maintenance programs, is probably associated with more deaths per kilogram than any of the illicit drugs such as heroin. There are only about 2,000 kilograms of the drug available each year in the United States, yet in 1992 the ratio of deaths associated with it nation-wide is about 1 to 8 when compared with heroin, a totally illicit drug. In New York, the ratio is 1 to 4. According to a recent letter (copy attached) which appeared in *The Lancet*, a prestigious medical journal, much the same experience has occurred in the United Kingdom.

Another problem in this area has been the resurgence of problems with tranquilizers such as existed in the 1950's. About two of every three mentions for licitly manufactured drugs among the top 20 drugs involve tranquilizers such as alprazolam (Xanax), Diazepam (Valium) and clonazepam (Klonopin), which has shown about a 400 percent increase from the first quarter of 1989 to the second quarter of 1993 and has been referred to in the illicit traffic as "Super Valium."

The data available also discloses that a great deal of fluctuation has occurred in the abuse of specific drugs over a period of time. In my experience, these fluctuations are clearly associated with identifiable phenomena. Almost every great upsurge involving a particular drug of abuse has been associated with the projection of a favorable image in the media and a sharp increase in availability. This was true in the case of LSD in the 1960's, and subsequently with both marijuana and cocaine. Many people have forgotten the many statements of prominent scholars, authorities and even government officials who said that marijuana was harmless and that cocaine could safely be used by many for recreational purposes. Some of the public, especially adolescents and young adults, responded to these statements, thus creating the current tragedy which has cost so much in lives and wealth on two continents.

Parenthetically, every decline in a specific drug problem has been linked to major enforcement actions, persistent adverse publicity, or a combination of the two. The problem of LSD in the 1960's was largely reduced by adverse publicity about violence and "bad trips". The

problem of methaqualone (Quaalude) was eliminated entirely through law enforcement action. And there is evidence that cocaine was reduced for a period due to large seizures and adverse publicity.

Unfortunately, as I have described, at present there are serious signs that some problems are again increasing. Also, as in the past when we saw these phenomena, we find that the media is once again filled with debate over legalization of drugs with the kind of polemic that encourages drug abusers to espouse their behavior as a right and proper exercise of freedom. We find once again that some scholars, authorities and even health officials are giving support to this confusion of national will. As you know, Mr. Chairman, this Administration is vehemently opposed to the legalization of drugs. Dr. Lee Brown, the Director of the Office of National Drug Control Policy, reiterated this position in an Op-Ed piece for *The Washington Times* yesterday by stating that legalization is not an idea that this Administration embraces in any form.

In summary, I have sought to catalogue some, but not all of the difficult challenges which we are facing. I must add that our knowledge of the demographics of the drug problem is considerable and discloses that although some drugs of abuse are related to specific groups, races and ages, virtually every segment of the population is involved. But it is the entire population of our country which is at risk because drug abusers and addicts inflict their suffering, disease, crime, violence and social costs on all of the rest of us. Drug abuse is a principal cause of irrational, and hence violent, and criminal behavior that threatens everyone. Nevertheless,

studies have shown an overall long-term decline in drug abuse among young people during the past 10 years. We clearly have the opportunity to preserve past gains if we persist in programs of proven value in government and in the private sector -- programs which show clearly and unequivocally that drug abuse is unacceptable and will not be tolerated.

Thank you for the opportunity to appear before you today. I have enclosed with my statement a number of charts for your reference. I will be pleased to respond to your questions.

influence of factors other than dietary-fat intake and plasma lipids. The role of endogenous hormones in middle-aged men should perhaps be considered.⁴

P Y Scarabin, L Bara, V Nicaud, J P Cambou, D Arveiler, G Luc, A E Evans, F Cambien

INSERM, Cardiovascular Epidemiology Unit, U258 Hôpital Broussais, 75 874 Paris, France; Thrombosis Laboratory of Paris VI; INSERM SC7, Paris; and MCHCA Registry of Northern Ireland and France

- 1 Scarabin PY, Bara L, Ricard S, et al. Genetic variation at the β -fibrinogen locus is related to plasma fibrinogen concentrations and risk of myocardial infarction: the ECTIM study. *Arterioscler Thromb* 1993; 13: 886-91.
- 2 Scarabin PY, Van Dreden P, Bouchon-Kopp C, et al. Age-related changes in factor VII activity in healthy women. *Clin Sci* 1988; 75: 341-43.
- 3 Elwood PC, Bewick A, O'Brien JR, et al. Temperature and risk factors for ischaemic heart disease in the Caerphilly prospective study. *Br Heart J* 1993; 70: 520-23.
- 4 Bouchon-Kopp C, Scarabin PY, Bara L, Castaigner M, Jacqueson A, Roger M. Relationship between sex hormones and haemostatic factors in healthy middle-aged men. *Atherosclerosis* 1988; 71: 71-76.

Voice restoration after laryngectomy

SIR—Johnson in his commentary (Feb 19, p 431) should have mentioned not only that many people who acquire a good voice after tracheo-oesophageal puncture and valve insertion would have developed good oesophageal speech anyway, but also that there is a substantial complication rate—eg, osteomyelitis of the cervical vertebrae,¹ retropharyngeal abscess, and carotid haemorrhage.² A patient on our unit, after a rather traumatic puncture, developed mediastinitis and a right pleural effusion, which required long-term intravenous antibiotics, chest drain insertion on three occasions, and three computed tomographic scans. She has spent 71 days of the past 7 months in hospital and still has no voice—the non-functional Provox valve having been removed—and a persistent tracheo-oesophageal fistula. The cost of treatment so far is about £20 000. Maybe this is one of the subjects that head and neck surgeons should consider in a country-wide audit, to see whether the benefits to some justify this high cost to others.

Carol Wengraf

Department of ENT and Head and Neck Surgery, Hull Royal Infirmary, Hull HU3 2JZ, UK

- 1 Cullen JR, Primrose WJ, Vaughan CW. Osteomyelitis as a complication of tracheo-oesophageal puncture. *J Laryngol Otol* 1993; 107: 242-44.
- 2 Spiro JD, Spiro RH. Retropharyngeal abscess and carotid haemorrhage following tracheo-oesophageal puncture and voice prosthesis insertion: a case report. *Otolaryngol Head Neck Surg* 1990; 102: 762-63.

Deaths from methadone and heroin

SIR—The UK Home Office Statistical Bulletin published in (London: HM Stationery Office, table 20 and p 53) reveals these figures for heroin and methadone deaths:

	1982	83	84	85	86	87	88	89	90	91
Heroin	11	13	24	19	16	22	24	36	34	44
Methadone	16	24	24	9	15	46	37	35	69	74

These figures give a total for the decade of 243 heroin deaths and 349 methadone deaths. In the same bulletin, notified addicts (overwhelmingly to opioids) totalled 24 700. At least 40% of notifications, it continues, are now of addiction to methadone, suggesting 9880 methadone addicts. Given that notifications register, at most, about one-fifth of all addicts, the total addict population in the UK is at least 123 500. If 9880

are addicted to methadone, this leaves 113 620 addicted to heroin; a tiny proportion will be addicted to other notifiable opioids such as dextromoramide (Palfium) or morphine.

In 1991, 44 heroin deaths out of 113 620 addicts yields a mortality of 1 in 2582; 74 methadone deaths of 9880 gives a mortality of 1 in 134. Thus methadone would appear to be 19 times more toxic than heroin, similar to previous findings in New York.³ Yet methadone is a manufactured pharmaceutical product whereas heroin is usually adulterated from the "street".

Police surgeons in London⁴ find that prescribing of methadone syrup by London's doctors is ineffective in stopping illicit drug use and, worse, the methadone is sold on. Furthermore, methadone produces disturbances of weight, sweating, sleep, and dyspnoea, in addition to greater numbers of fatalities.^{2,4,5} Given the dangers of methadone and its apparent ineffectiveness, perhaps the current vogue for methadone in the management of addiction should be reviewed.

John Marks

Chapel Street Clinic, Widnes, Cheshire WA8 7RE, UK

- 1 AIDS and drugs misuse. Part 1. Report of the Advisory Council on the Misuse of Drugs. London: HM Stationery Office, 1988; 1: 13.
- 2 Lippman JA, Jenner FA, Vincent B. Literature on methadone maintenance clinics. *Int J Addict* 1988; 23: 927-40.
- 3 Payne-James JJ, Dean PJ, Keys DW. Drug misusers in police custody. *J R Soc Med* 1994; 87: 13-14.
- 4 Ghodse A, Sheehan M, Taylor C, Edmonds G. Deaths of drug addicts in the UK 1967-1981. *BMJ* 1983; 286: 425-28.
- 5 Swenson G. Opioid drug deaths in Western Australia: 1974-1984. *Aust Drug Alcohol Rev* 1988; 7: 181-85.

Prostate cancer

SIR—Layne is a great scientist who has made major contributions to prostate cancer treatments, but he is wrong in his report (Feb 19, p 491) about the adrenal glands being "... responsible for close to half the total androgens in adult men and not a 'small extent' ...". My reference works (DeGroot, *Endocrinology* 1989, p 2146; Campbell, *Urology* 1986, p 248; and Lepot et al, *Prostate diseases* 1993, W B Saunders, p 62) all indicate that a very low percentage comes from the adrenal cortex, as does my personal experience. I am a white male, age 75, weight 175 lbs, height 6 feet, diagnosed with stage B prostate cancer, Gleason's grade 2 cells, on Nov 16, 1993. My prostate-specific antigen (PSA) was 10.5 ng/mL and my testosterone 341 ng/dL (normal = 300-1000) on Dec 2, 1993. I had bilateral orchiectomy on Dec 8, 1993, and on Jan 6, 1994 had a testosterone of less than 20 ng/dL and a PSA of 1.9 ng/mL. The orchiectomy had knocked out the prostate cancer and at least 94% of my androgens. The remaining 6% were coming from my adrenal glands.

Victor T Cheney

374 Gardner Drive, Ft. Walton, FL 32548, USA

Authors' reply

SIR—Cheney's comments are in perfect agreement with textbooks. However, textbooks do not contain the newest knowledge. In fact, information on the formation of androgens and oestrogens in peripheral tissues from the inactive adrenal precursors dehydroepiandrosterone (DHEA) and DHEA sulphate (DHEA-S)¹ is not yet in textbooks.

The residual 5% testosterone serum concentrations after medical (luteinising hormone releasing hormone [LHRH] agonist) or surgical castration result from some leakage of testosterone into the circulation from peripheral tissues where

DAWN ESTIMATED EMERGENCY ROOM MENTIONS TOP TWENTY CONTROLLED SUBSTANCES NATIONALLY

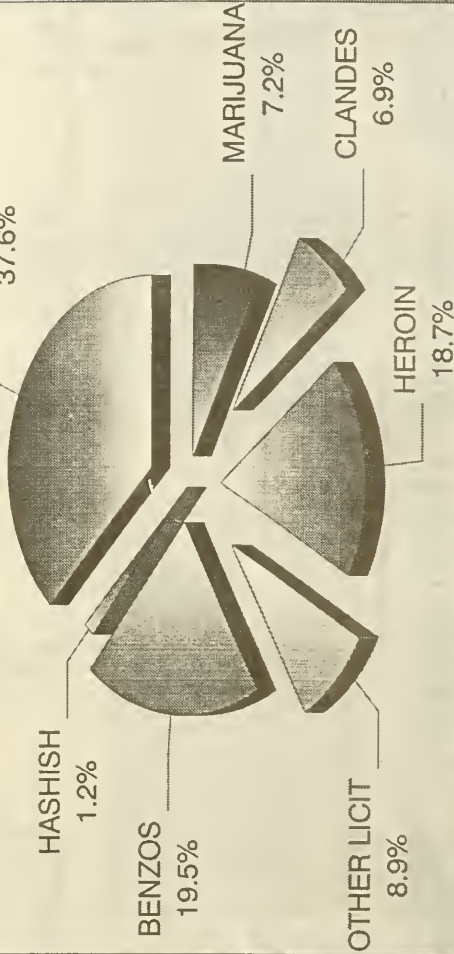
JANUARY - JUNE SOURCE: BILL COACH, STATISTICIAN

DRUG	1993	1992	% CHANGE
COCAINE	(1) 61,050	(1) 57,723	5.8
HEROIN	(2) 30,376	(2) 20,837	45.8
MARIJUANA	(3) 11,730	(3) 10,047	16.8
ALPRAZOLAM	(4) 8,344	(4) 8,314	0.4
DIAZEPAM	(5) 6,618	(5) 6,639	-0.3
CLONAZEPAM	(6) 5,017	(8) 4,159	20.6
LORAZEPAM	(7) 4,829	(6) 4,318	11.8
CODEINE COMB	(8) 4,389	(7) 4,202	4.4
D-PROPOXYPHENE	(9) 4,232	(10) 3,247	30.3
METHAMPHETAMINE/SPEED	(10) 4,182	(12) 2,592	61.3
UNSPEC BENZODIAZEPINE	(11) 3,519	(9) 3,300	6.6
PCP & PCP COMB	(12) 3,286	(13) 2,266	45.0
HYDROCODONE	(13) 2,590	(11) 3,201	-19.1
AMPHETAMINE	(14) 2,264	(16) 1,659	36.5
HASHISH	(15) 2,003	(19) 1,469	36.4
CHLORDIAZEPOXIDE	(16) 1,702	(17) 1,555	9.4
OXYCODONE	(17) 1,686	(18) 1,541	9.4
TEMAZEPAM	(18) 1,587	(14) 1,754	-9.5
LSD	(19) 1,533	(15) 1,751	12.4
METHADONE	(20) 1,484	(20) 1,448	2.5

DAWN EMERGENCY ROOM MENTIONS TOP TWENTY CONTROLLED SUBSTANCES

NATIONALLY SOURCE: BILL COACH, STATISTICIAN

JAN - JUN 1993 COCAINE 37.6%



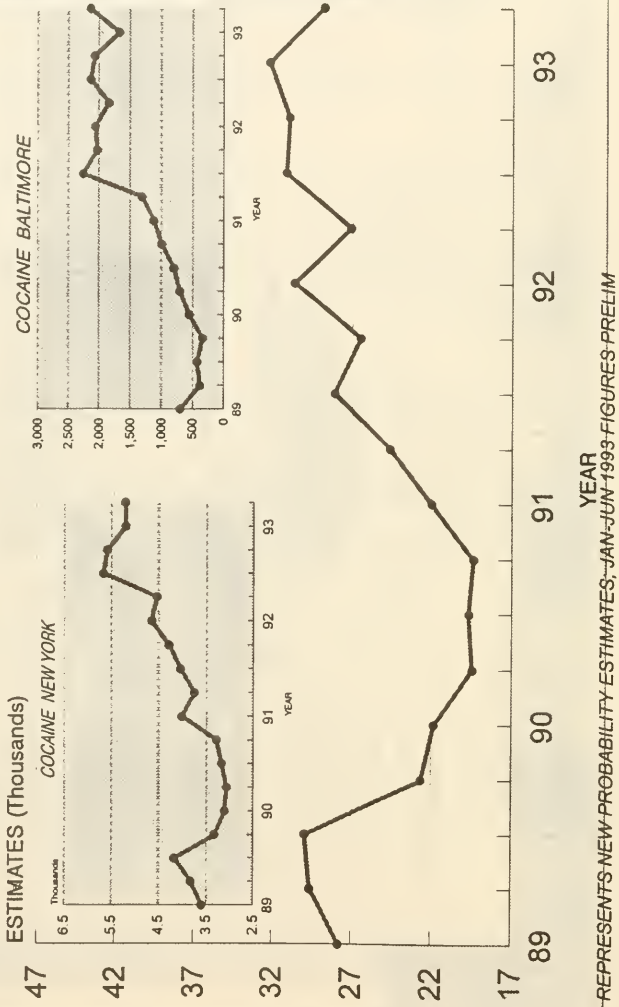
CLANDES INCLUDES METHAMPHETAMINE/SPEED, LSD, PCP & PCP COMB, AND AMPHETAMINE

OFFICE OF DIVERSION CONTROL

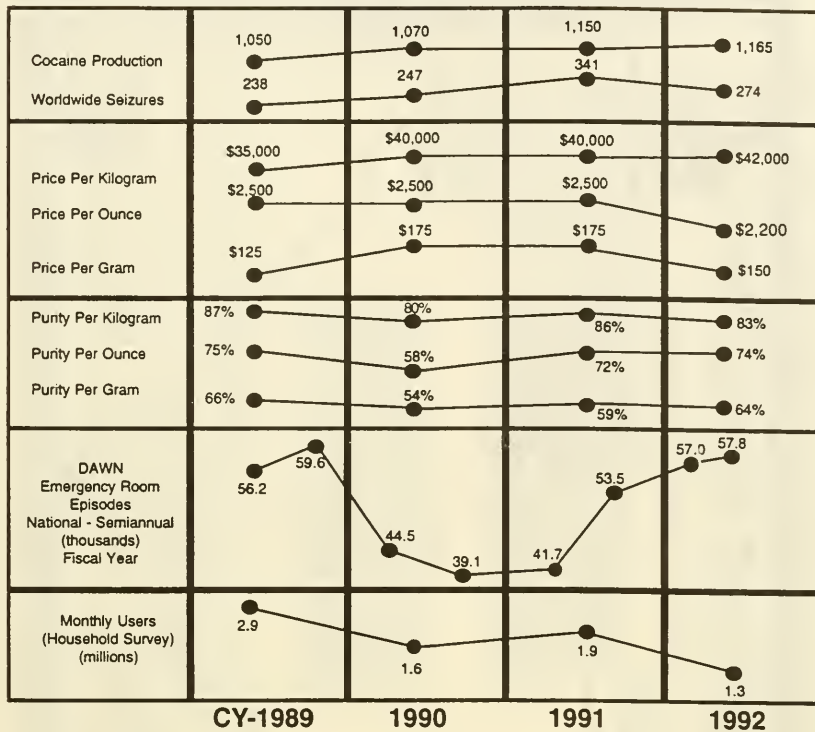


DAWN ER EPISODES COCAINE NATIONALLY

SOURCE: BILL COACH, STATISTICIAN



COCAINE INDICATORS



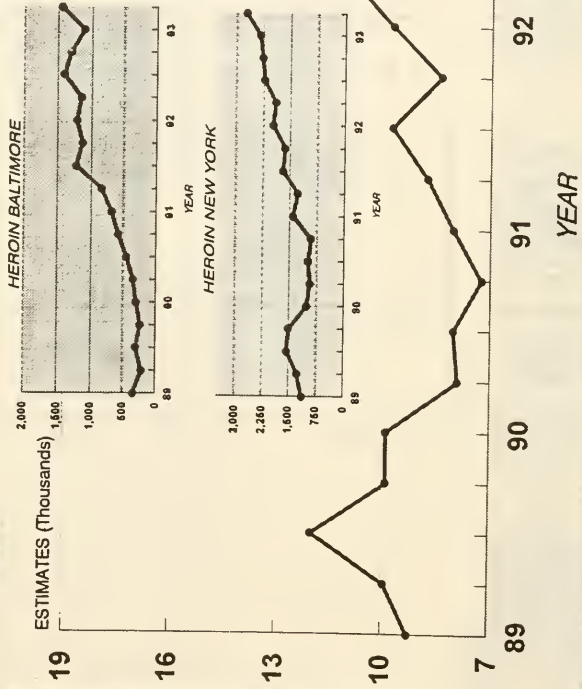


DAWN ER EPISODES HEROIN NATIONALLY

OFFICE OF DIVISION CHIEF



SOURCE: BILL COACH, STATISCIAN



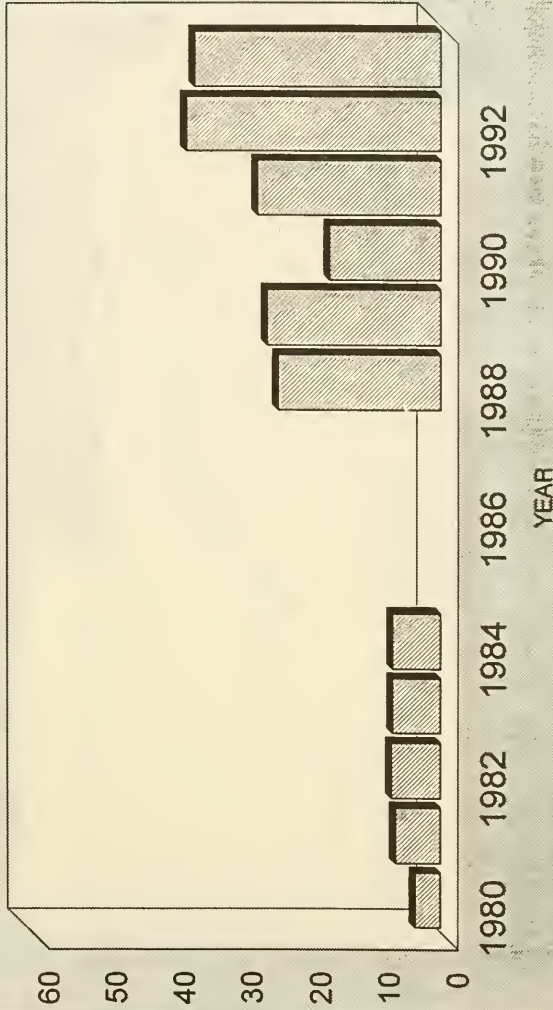
REPRESENTS NEW PROBABILITY ESTIMATES, JAN-JUN 1993 FIGURES PRELIM



DOMESTIC MONITOR PROGRAM HEROIN PURITY

PERCENT

DRUG ENFORCEMENT ADMINISTRATION



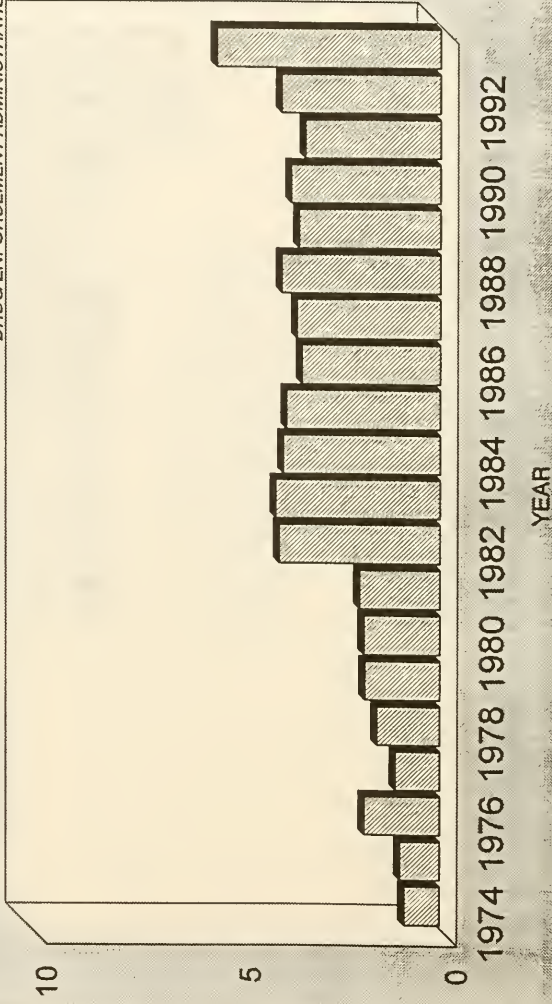
NOTE: THE SYSTEM WAS NOT IN OPERATION IN 1985, 1986, AND 1987

MARIJUANA THC MONITORING PROJECT COMMERCIAL GRADE



DRUG ENFORCEMENT ADMINISTRATION

PERCENT



YEAR

DRUG ENFORCEMENT
ADMINISTRATION



JUVENILE ARRESTEES

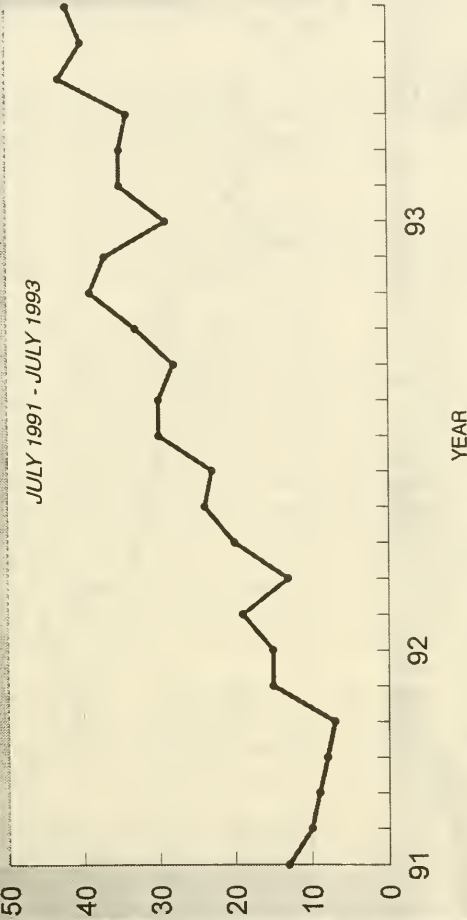
POSITIVE FOR MARIJUANA
WASHINGTON D. C.



OFFICE OF DIVERSION CONTROL

JULY 1991 - JULY 1993

PERCENT



YEAR

SOURCE D.C. PRETRIAL SERVICES

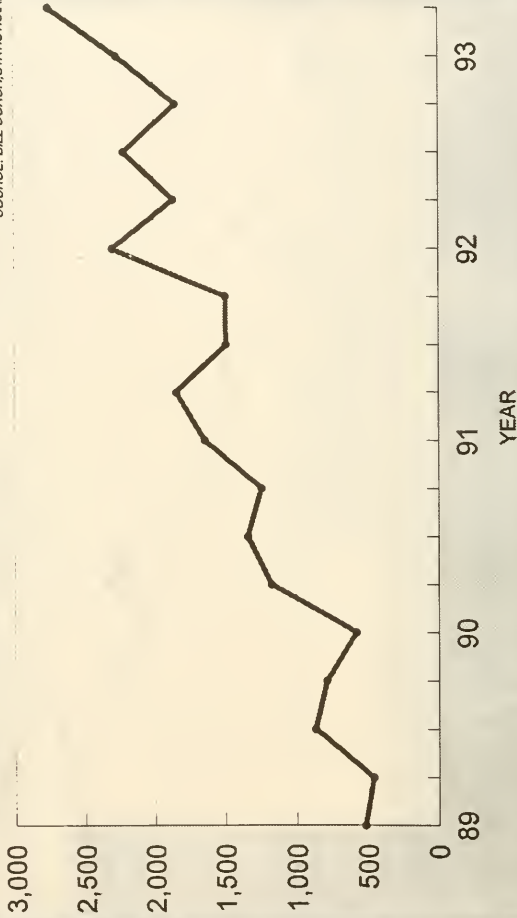
OFFICE OF DIVERSION CONTROL



DAWN ER EPISODES CLONAZEPAM NATIONALLY



SOURCE: BILL COACH, STATISTICIAN



REPRESENTS NEW PROBABILITY ESTIMATES; 1993 DATA PRELIMINARY

Mr. CONDIT. Thank you, sir.

Our next witness is Ms. Petrie. She is with the U.S. Department of Justice.

STATEMENT OF CAROL PETRIE, ACTING DIRECTOR, NATIONAL INSTITUTE OF JUSTICE, U.S. DEPARTMENT OF JUSTICE

Ms. PETRIE. Yes, good morning, Mr. Chairman. I am Carol Petrie. I am the Acting Director of the National Institute of Justice, and I appreciate the opportunity to be here today to discuss the work of the National Institute of Justice with regard to the abuse of illegal drugs.

As requested, I will focus on data gathered through NIJ's drug use forecasting program, and I would like to submit my full testimony to the record, but I will briefly summarize and hit the highlights here for you.

Mr. CONDIT. Absolutely. We appreciate that.

Ms. PETRIE. OK. I do want to do a little bit of context setting and just lay out in a few broad brush strokes the context in which we should consider some these findings, and that context is from research over about the past 10 years that NIJ has conducted relating to substance abuse. The findings from that body of research include that frequent use of hard drugs is one of the strongest indicators of criminal careers, that drug-abusing offenders are among the most serious and active both in terms of property and violent crimes, that early persistent cocaine or heroin use in the juvenile years is an indicator of serious and persistent criminal behavior in adulthood, and that is important in terms of our drug use forecasting findings for juveniles, which I will speak about in a few minutes.

Arrestees using drugs are more likely than nonusers to be rearrested on pretrial release or to fail to appear at trial, and effective treatment requires that offenders stay in a treatment program for longer than 3 months and get followup treatment in the community.

Within that context then, I would like to go ahead and discuss our drug use forecasting findings. To briefly review, the DUF program provides information on drug abuse among persons arrested for serious offenses in 23 booking facilities throughout the country. The program is unique in that it provides hard data on drug abuse obtained through urine or hair testing as well as self-reported information from arrestees themselves.

As other panelists have indicated and I am sure my colleagues here will indicate, the evidence regarding drug abuse abatement in the general population is mixed, it is up, it is down, but among those NIJ is concerned with, the hardcore users that are frequently involved with the criminal justice system, the DUF data clearly show the drug problem at its most acute.

NIJ is now reviewing our 1993 drug use forecasting annual report, and we will submit that to the committee as soon as we publish it. But I just want to highlight some of the trends that we are watching.

Drug abuse among this population remains high and relatively steady. In 1993, the median percentage of adult arrestees testing

positive for any drug was 63 percent for men and nearly 68 percent for women. So what this means is that in half of our DUF sites 63 percent of the men that we tested were positive for a drug and 68 percent of the women in half of the sites.

Cocaine remains the most prevalent drug. The overall trend for male arrestees is steady or decreasing slightly. We do see major shifts in cocaine in a few places. In Indianapolis, for example, cocaine is up to 32 percent of the DUF sample in 1993. That is up from 23 percent in 1992, so there is a 10 percent increase there. In Denver, cocaine use among men climbed from 24 percent in 1990 to 41 percent in 1993. In Philadelphia and San Jose, cocaine use is at the lowest percentage since the DUF program began in 1987, but still in Philadelphia it is at 56 percent of the sample that is tested; in San Jose it is 23 percent. DUF indicates similar trends for women, either steady or dropping slightly.

For marijuana, following decline, in 1991 marijuana use among male arrestees climbed in half the sites. No sites significantly decreased. In Chicago, Detroit, and Phoenix, the increases were at 9 percent or greater. The marijuana increase is not as significant among women, but most localities show steady or increasing rates.

Over the past 2 years, NIJ has tracked changes in opiate use trends among arrestees in light of DEA findings regarding the availability of heroin. Among this arrested population, except in Chicago, we see no dramatic change testing positive for heroin. In Chicago, opiate use among men increased from 19 percent in 1992 to 28 percent in 1993. We don't know what the reason for this is; we see this only in one site. It may be that—the fact that the price is down, and in Chicago there are open air heroin markets, that that is the reason for this increase there; it may be that the police are arresting more people who are associated with this heroin market, and so it may be just a blip because of police activity that we would not see in the rest of the arrested population in the city of Chicago. But we just don't know what that is about, and we are going to continue to track that and do some analysis on that.

I would like to concentrate now on two populations that we feel need special attention. In 12 of our sites, we test juveniles who are detained at a booking facility. The percentage of young people in 1993 testing positive for any drug ranged from 18 percent to 54 percent. Places like Indianapolis and Birmingham are at the low end of that range, and places like Denver and Cleveland and the District of Columbia and Phoenix are at the high end of that range.

In 8 of the 12 sites, more than a quarter of the juveniles test positive for some drug, usually marijuana. Marijuana continues as the most prevalent drug detected. In most DUF juvenile sites, less than 10 percent of the juveniles test positive for cocaine using the regular testing protocols in the DUF program.

We also have found that young men not in school are more likely to test positive. Although 68 percent of those detained said they were still in school or had obtained a GED, still, the ones who were not in school were more likely to be positive on the test.

Generally the DUF data, especially when you consider it in the context of other research information, suggests a focus on young people and on treatment. Juvenile drug use may be even higher than normal DUF protocols indicate. In a pilot study we conducted

in two DUF sites, Cleveland and St. Petersburg, using hair testing of juveniles, we detected six times more cocaine use than we detected with urinalysis. We are now going to extend that study to a larger and more ethnically diverse group of juveniles.

NIJ also experimented with lower cutoff levels for marijuana in 1991 research on a DUF sample. We essentially cut the cutoff rate that was used by NIDA and by us in our regular testing in half, and while generally only modest increases in drug positives showed up among adults, we had a greater difference among juveniles. Overall, there was a 4 percent increase in detection of marijuana, but in some sites it increased by as much as 50 percent.

Research also shows onset of drugs and delinquency occur at generally the same age. All of this points to the need to focus on screening juveniles and getting them into treatment. We believe that for juveniles the combination of drug abuse and a serious enough offense for which you are detained—your offense is serious enough to be detained as a juvenile and you are also using drugs, that this is a red flag that serious criminal behavior may persist into adulthood, and that these are the individuals who should be essentially targeted for priority treatment in whatever treatment systems are available to these offenders.

Our research has also focused on women. Women have drug use rates that are higher than males in our sample, but treatment has lagged because women comprise such a small percentage of persons who are caught up in the criminal justice population.

NIJ has found that far too few treatment programs attack problems that contribute to drug use and other destructive consequences for women; for example, the lack of job training, parenting skills. Most incarcerated women are parents and will be responsible for their kids when they are released.

NIJ is also currently examining substance abuse treatment with violence reduction therapy for domestic violence offenders. We also need more evaluations of innovative treatment programs for special populations such as domestic violence offenders. In 1994 and 1995, NIJ will support evaluations of comprehensive treatment and aftercare programs for women which will include counseling, psychotherapy, education, job training, and child care.

Thank you, Mr. Chairman, and if you have any questions, I would be pleased to answer them.

[The prepared statement of Ms. Petrie follows:]



Department of Justice

STATEMENT

OF

CAROL V. PETRIE
ACTING DIRECTOR
NATIONAL INSTITUTE OF JUSTICE

BEFORE

THE

SUBCOMMITTEE ON INFORMATION, JUSTICE,
TRANSPORTATION AND AGRICULTURE
COMMITTEE ON GOVERNMENT OPERATIONS
HOUSE OF REPRESENTATIVES

CONCERNING

DRUG USE FORECASTING PROGRAM

ON

MAY 25, 1994

Good morning, Mr. Chairman and members of the Subcommittee.

I appreciate the opportunity to be here today to discuss the work of the National Institute of Justice in preventing and controlling illegal drug use. As you requested, my statement will focus on data gathered by NIJ through its Drug Use Forecasting Program as well as information from the Institute's research on substance abuse.

First, I would like to note briefly that the National Institute of Justice has been working in drug control research for a number of years. Since 1985, for example, NIJ has invested some \$20 million in research, development, and evaluation relating to substance abuse. The accumulated findings have played a significant role in efforts to control drug use and trafficking through innovative enforcement techniques directed at street drug markets as well as community-based prevention programs and treatment for drug-abusing offenders. Some of the findings of this body of research show that:

- ♦ Frequent use of hard drugs is one of the strongest indicators of a criminal career.
- ♦ Offenders who abuse drugs are among the most serious and active criminals, engaging in both property and violent crimes.
- ♦ Early and persistent use of cocaine or heroin in the juvenile years is an indicator of serious, persistent

criminal behavior in adulthood.

- ♦ Arrestees who are drug users are more likely than those not using drugs to be rearrested on pretrial release or to fail to appear at trial.
- ♦ Treatment for drug-involved offenders can be effective if clients are retained in the program for longer than 3 months and if the program is followed with coordinated postrelease programs in the community.

Substance abuse and drug-related crimes continue to affect the lives of countless Americans in both urban and rural areas. For this reason, efforts to counter the problem remain one of the Institute's six long-range goals. More recently, NIJ has expanded its focus in this area to include study of the link between alcohol and violent behavior, in response to findings of the National Academy of Science Panel on Understanding and Preventing Violence.

Drug use and the offender population

Evidence that drug abuse has been abating in the general population is mixed. NIJ is focusing on the real locus of the problem -- the hard core users who are frequently involved with the criminal justice system. As NIJ's Drug Use Forecasting--or "DUF" -- program has amply demonstrated, it is in this group that the drug problem is most acute.

To briefly review, DUF provides information on drug use among persons arrested for serious offenses in 23 booking facilities throughout the country. The program is unique in that it provides hard data on drug use -- obtained through urine or hair testing -- as well as self-reported information from the arrestees themselves.

Participation rates have been consistently high in all of the DUF sites, typically above 80 percent. The majority of males who are tested have been arrested on non-drug felony charges. In the female and juvenile samples, larger numbers of misdemeanants are included.

1993 DUF findings and trends

Before I report on the most recent annual statistics and trends revealed by DUF, I would like to inform the members of the subcommittee that the 1993 Drug Use Forecasting Annual Report, will be published shortly, and will be made available to the subcommittee at that time.

DUF continues to detect high levels of drug use among this population. In 1993, the percentage of male arrestees testing positive for any drug ranges from 54 percent to 81 percent; for female arrestees, the rate is from 42 percent to 83 percent. Across all sites, the median percentage for men arrestees is 63

percent; for women it is nearly 68 percent. This information is compiled in a table attached to my statement (Table 1).

Cocaine

Except for the few sites where cocaine use fluctuated dramatically, the DUF program continued to detect little significant change in cocaine use since 1990. Cocaine remains the most prevalent drug, and the overall trend for male arrestees remained steady or decreased slightly.

In a few localities, DUF revealed major shifts in cocaine use: In the sample in Indianapolis, for example, cocaine use increased to 32 percent in 1993, up from 23 percent in the previous year. In Denver, cocaine use among the male sample continued to climb - from 24 percent in 1990 to 41 percent in 1993.

On the other hand, cocaine rates for men testing positive in Philadelphia and San Jose were at the lowest percentage since the inception of their DUF programs. Philadelphia reported 56 percent, and San Jose, 23 percent.

For arrested women, DUF results indicate a similar trend, with most sites remaining steady or dropping slightly. As with the men, women testing positive for cocaine in Indianapolis rose from 25 percent in 1992 to 36 percent in 1993. Decreases in cocaine

use among women tested were found in San Jose, where it dropped from 32 percent in 1992 to 19 percent in 1993; and in Phoenix, where it declined from 49 percent in 1992 to 38 percent in 1993.

Marijuana

In 1992, the DUF program reported that marijuana began to rise, following a decline in use seen in 1991. For 1993, marijuana use among male arrestees climbed in half the sites, and no site reported a significant decrease. In three sites -- Chicago, Detroit, and Phoenix -- the increases were 9 percent or greater. For arrested women, marijuana use did not rise as significantly, but all localities testing women saw steady or increasing rates. The exception was Dallas, where marijuana use among arrested women dropped from 24 percent in 1992 to 19 percent in 1993.

Opiate use

DUF monitors opiate use very closely. As you know, the Drug Enforcement Administration has reported greater availability, increased purity and lower prices for opiates. DAWN (Drug Abuse Warning Network), a program of the National Institute on Drug Abuse, has reported an increase in heroin-related emergency room admissions. Over the past two years, NIJ has been tracking changes in opiate use trends among arrestees sampled by DUF. With the exception of Chicago, DUF results show no dramatic change in

arrestees testing positive for heroin or opiates. In Chicago, opiate use among arrested men increased from 19 percent in 1992 to 28 percent in 1993. The program will continue to watch the change in Chicago, along with any fluctuations in the other DUF sites in 1994.

Multiple drug use

The DUF program tests reveal drug use that occurred within 48 hours of the individual's arrests. Given this window, multiple drug use shows up less frequently than do separate drugs. In 1993, arrestees testing positive for more than one drug ranged from 13 percent to 42 percent for men and 14 percent to 39 percent for women. Across all sites, the midpoint was around 20 percent for both men and women. In some sites, however, multiple drug use was much more pervasive. In San Diego, for example, 42 percent of the men and 39 percent of the women tested positive for more than one drug in 1993.

Drug use by juveniles

The DUF juvenile sample in most sites includes only those young people arrested and detained for 24-hours or more at larger juvenile facilities. Those juveniles arrested, processed, and released at the local precinct are not captured in the DUF samples.

The percentage of young people testing positive for any drug in 1993 ranged from 18 percent to 54 percent. The variation may be attributable to site differences, but some trends are seen. Between 1992 and 1993, increasing numbers of sites have found that more than a quarter of more of the juveniles are testing positive for any drug. In 1992, this was true in only 6 of the 12 sites testing juveniles; in 1993, 9 of the sites reported drug positives at the 25 percent level or greater.

Marijuana and cocaine

As in previous years, marijuana is the most prevalent drug detected among male juveniles arrested or detained. In the majority of DUF juvenile sites (10 out of 12), under 10 percent tested positive for cocaine in 1993.

Other information

While DUF primarily produces statistical information, it is also a source of information about a number of other important public policy issues. Each DUF participant is interviewed and basic demographic data are obtained as well as a number of personal attributes such as drug use history, source of income, education level, treatment experience, and use of needles. The localities participating in DUF use this information, in conjunction with

data from other sources, to guide policies and develop and evaluate treatment and prevention programs.

Demographics

Because DUF focuses on those arrested and charged for serious offenses, DUF samples are not a mirror of the larger local arrested population from which they are drawn. DUF samples for adult males, for example, are composed of larger proportions of felons and include fewer numbers of individuals charged with specific drug offenses such as possession or intent to distribute small quantities of drugs. This selection process thus shapes the demographic characteristics of the DUF sample.

Although it is not possible to aggregate DUF data, we can draw from the data the general picture of the sample in most sites. DUF samples are composed of disproportionate numbers of racial minorities. The predominant age is between 20 and 30. These figures are consistent with national arrest statistics for serious offenders.

Among juveniles, 68 percent reported in 1993 that they are either still in school or have graduated or obtained a GED. With the exception of Denver, young men not attending school were more likely to test positive for any drug than those who said they were in school.

Prevention and treatment

The criminal justice system is the single largest source of pressure on abusers to obtain treatment. Unless required by the court, substance abusers are unlikely to enter or complete treatment programs. Half or more of the admissions to typical residential or community-based treatment programs are clients of probation and parole agencies.

However, providing drug treatment presents many challenges for criminal justice agencies. Arrestees generally possess few of the characteristics that treatment providers prefer in their clients. Many have already failed in treatment. Few have the links to law-abiding society necessary to sustain them through treatment and follow-up.

Nevertheless, the benefits of treatment -- which include a reduction in drug use and related criminal behavior -- are compelling. For this reason, the Office of National Drug Control Policy has called on all criminal justice system components -- enforcement, prosecution, adjudication, and corrections -- to promote drug treatment.

NIJ research and evaluation is helping meet these challenges by assessing treatment needs, identifying ways to improve treatment, and focusing on specific groups such as women offenders.

Assessing Treatment Needs

Lack of motivation by offenders to participate genuinely and fully in treatment is the most serious obstacle criminal justice faces. Even if they acknowledge their drug dependency, many -- perhaps most -- offenders cannot sustain the motivation to persist in the often uncomfortable restrictions of the treatment regimen.

In 1993, for example, interviews with those in the DUF sample showed that 21 percent of the men and 28 percent of the women said they currently needed drug treatment. Since these figures are far lower than the number testing positive, it is reasonable to assume that the number of individuals who could benefit from treatment -- even unwillingly -- is much higher. Furthermore, for both men and women in the DUF sample, arrestees expressing a need for treatment were more likely to test positive for a drug, and thus establishing a definitive treatment need, than arrestees not reporting such a need. For example, 5 percent of female arrestees who did not test positive for any recent drug use reported feeling that they could use drug treatment; 36 percent reported a need in those testing positive for one drug; 48 percent in those women who tested positive for two or more drugs. Therefore DUF findings also indicate that those persons reporting a greater need for treatment are seriously involved in drugs (as measured by urinalyses). This information is compiled in a table attached to my statement (Table 2).

Much research, both by the Federal Government and private organizations, has focused on ways to treat the recalcitrant client. These include research on matching specific treatment practices to specific types of offenders, exploration of the use of graduated sanctions to compel the offender's compliance with treatment and supervision requirements; and use of new technologies to detect continued drug use by those ostensibly in treatment.

Development of new technologies to detect drug use is sponsored primarily by agencies outside the criminal justice field. Criminal justice professionals are vitally interested in the application of these technologies, however, because many illicit substances -- such as synthetic drugs and hallucinogens -- cannot be adequately detected by current methods. There is a small but growing body of ethnographic evidence that implies that young people are increasing use of these substances.

Juvenile Hair Testing

In addition to urinalysis screening for drugs, NIJ has explored the effectiveness of hair testing. Our research indicates that hair testing offers a wider window of detection; in fact, hair retains an almost permanent record of previous drug use. Thus, the technology promises to be a useful complement to urinalysis,

with its shorter detection period.

In a pilot study in two DUF sites -- Cleveland and St. Petersburg -- hair testing of juveniles detected six times more drug use than did urinalysis. Building on this research, NIJ is now conducting another project to compare hair testing and urinalysis and determine whether drug use among juvenile arrestees has been underestimated. The study has been extended to include a larger and more ethnically diverse segment of the juvenile arrestee population and to identify the probability of drug abuse for specific types of offenders.

Specialized Treatment Needs

As I pointed out earlier, the DUF program has consistently shown that rates of drug abuse among women arrestees are higher than those for males. Because women make up only a small proportion of the criminal justice population, development of treatment resources for them has lagged.

The consequences of drug abuse in women are clearly far-reaching. The numbers of drug-exposed children born to them and their increased exposure to HIV infection strain medical and social resources. Many of them are parents, and they will continue to be responsible for their children when they are released. Most incarcerated women are parents.

Treatment programs that do not respond to these unique needs cannot be effective. A recently completed NIJ-sponsored survey of drug treatment programs for females confirmed that while many programs provide treatment for drug dependency, far too few provided services directed at the problems that greatly contribute to drug use, such as the lack of job training and parenting skills.

Prevention efforts for young people

More effective approaches for discouraging young people from drug use is another key need. Prevention programs need to provide an array of services that can compensate for the disadvantages and challenges young people are facing today. NIJ's evaluation program is examining several approaches.

One is the Children At Risk program now under way in six cities. The program is a unique public/private partnership between the Department of Justice, BJA, NIJ, and the Office of Juvenile Justice and Delinquency Prevention, and six private nonprofit foundations.

The program is aimed at youths between 11 and 13 years of age and their families. Cities operating the programs are: Austin, Texas; Bridgeport, Connecticut; Memphis, Tennessee; Newark, New Jersey; Savannah, Georgia; and Seattle, Washington. Although each

city's program is somewhat different to accommodate specific needs, all provide family services such as counseling and parenting skills, education assistance such as tutoring and help with homework; mentoring; afterschool and summer activities; as well as intensive case management and coordinated participation by all parts of the criminal justice and juvenile justice system.

We expect to learn about how the different aspects of the program are working under different circumstances and for different types of children and families. With this information, NIJ will be able to guide other communities in adopting the model.

Innovations in Treatment

Criminal justice officials want to close the "revolving door" that brings drug offenders to court again and again. This is the concept behind an innovative program in Dade County, Florida, which NIJ evaluated.

The Miami Drug Court, as it's known, diverts nonviolent drug users from the traditional path of streets to court to jail and provides, in its stead, a three-phase alternative that consists of detoxification, stabilization, and aftercare. I'll take just a moment to describe briefly for you how the program works.

Once assigned by the court to the Diversion and Treatment

Program, clients are processed at a main treatment clinic and then enter the detoxification phase, which can last up to six weeks. During this time the clients receive both individual and group counseling and are subjected to daily urine testing. The client and a trained counselor cooperate in the preparation of a treatment plan that includes realistic and measurable short-term and long-term goals. And finally, a "psychosocial assessment" provides the counselor with information about the client's needs and history for use in developing a continuing treatment plan.

Clients in the stabilization phase concentrate on maintaining abstinence by continuing their counseling sessions and attending fellowship meetings, much like those employed in the Alcoholics Anonymous programs.

In the aftercare phase attention is paid to the client's success in staying off drugs; attending counseling sessions, fellowship meetings, and court hearings; and progress toward achieving the goals of the treatment plan. Clients are encouraged to prepare themselves academically and occupationally for their future; they discuss with their counselors issues of maintaining sobriety that may arise; they are encouraged to do things without the help of treatment staff and to concentrate on the educational and vocational help they want. Community college faculty provide literacy training and GED classes; program counselors encourage qualified clients to enroll in regular day classes at the

community college; financial aid counselors are available to help clients apply for financial aid; training in work skills and job development abilities are available, along with lists of current employment opportunities, apprenticeship programs, and training programs.

Throughout the term of the program, clients are closely monitored by the drug court judge -- Stanley M. Goldstein. Judge Goldstein talks with each client at least weekly, keeps track of the client's urine testing results, and maintains an up-to-date client treatment and progress record on his computer.

NIJ's evaluation of the Miami Drug Court showed some promising results. The researchers focused on defendants over an 18-month period and compared them to similar defendants not in the program. They found that the Drug Court defendants had:

- ♦ Lower incarceration rates. Far fewer Drug Court defendants than other felony drug and non-drug defendants were sentenced to incarceration for more than a year.
- ♦ Less frequent rearrests. Drug Court defendants generated somewhat lower rates of reoffending, as indicated by rearrests, than non-drug felony defendants; they accounted for notably lower

reoffending rates than other felony drug defendants.

- ♦ Longer times to rearrest. When Drug Court defendants were rearrested, the lengths of time to their first rearrests averaged from two to three times longer than those in the comparison groups.

The strengths of the Drug Court program included strong joint support for the program by the judiciary, the prosecutor, and the defender; the leadership of Judge Stanley Goldstein, who is familiar with drug-influenced behavior, was also an essential element in the program's success.

NIJ has published two reports on the Miami Drug Court within the past year: a *Program Focus*, which describes the workings of the program in detail; and an *Evaluation Bulletin*, which summarizes NIJ's evaluation of the program. Copies of these documents are included along with my statement for your reference.

The Bureau of Justice Assistance (BJA) is planning in FY 1995 to fund a number of second generation drug courts that incorporate ideas for improvements based on the NIJ evaluation of the Miami Drug Court prototype. In some instances, BJA funding will be used to create new drug courts; in others, BJA resources will be used to reorganize and coordinate an existing infrastructure. In its FY 1994-95 Program Plan, NIJ is soliciting proposals to

evaluate these BJA-funded drug court experiments.

NIJ's Long-Range Plan

The effort to reduce drug and alcohol-related crimes is a major goal of NIJ's long-range plan. The Institute's research and evaluation priorities, which have focused on drug abuse prevention and efforts to curb traffic in drugs, now incorporates an emphasis on reducing both drug and alcohol demand.

In FY 1994-95, NIJ will give priority to two research and evaluation areas aimed at clarifying the relationship between substance abuse and crime. NIJ intends to investigate the relationship between alcohol and violence, particularly to understand more fully how substance abuse is related to domestic violence and whether the effectiveness of violence reduction therapies might be improved by addressing client substance abuse at the same time.

A current NIJ study is examining the use of combined substance abuse treatment with violence reduction therapy for domestic violence offenders, but more evaluations of innovative treatment programs for such special populations are needed.

In addition, NIJ will evaluate comprehensive substance abuse

treatment aftercare approaches -- counseling, psychotherapy, education, job training, and childcare, to mention a few -- and will explore why clients drop out of treatment programs.

Thank you, Mr. Chairman. I would be pleased to answer any questions you may have.

Table One

Any Drug Use by Male and Female Booked Arrestees, 1993*

Source: National Institute of Justice/Drug Use Forecasting Program

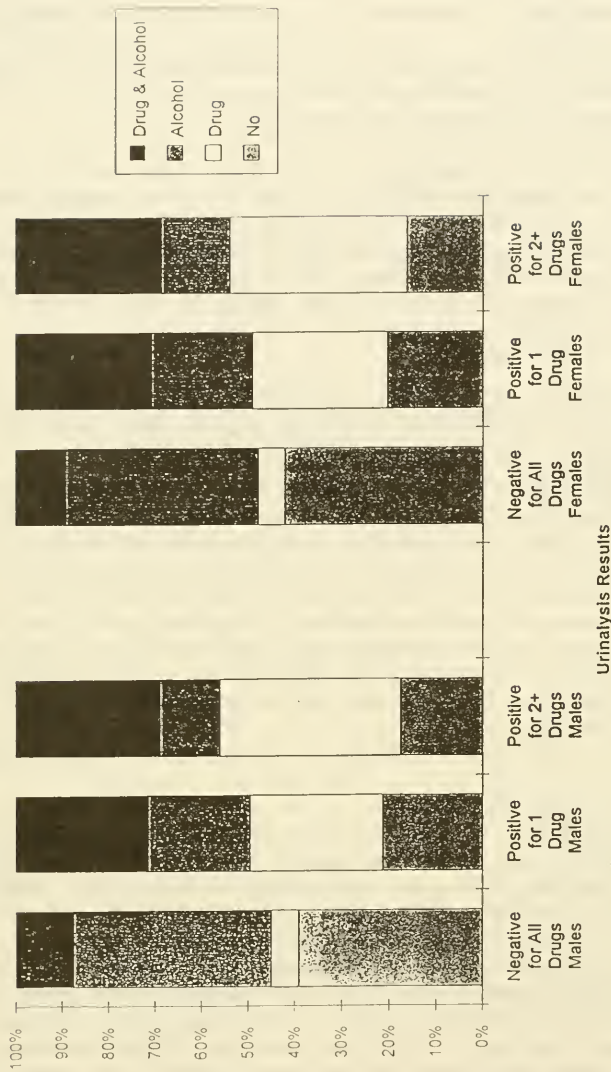
* Positive by urinalysis: January through December 1993

* Less than 20 cases

 Males
 Females

The Drug Use Forecasting Program: Table Two

1993 Male and Female Booked Arrestees:
Need for Treatment by Urinalysis Drug Test



Source: National Institute of Justice/Drug Use Forecasting Program

Mr. CONDIT. We do have some questions, and I do appreciate your testimony. I have to go vote. I have a few minutes. Do you have a problem?

I will be right back, and if a member shows up we will start and, Dr. Melnick, we will start with you when come back. Is that fine?

Excuse me just for a few minutes.

[Recess taken.]

Mr. CONDIT. I apologize for the delay and would advise the witnesses it would be helpful, if you have a lengthy statement, to maybe include that in the record, and if you can paraphrase or shorten it, I would appreciate it. If you don't want to do that, you are welcome not to do that. The only reason I am suggesting that is that it appears that votes are going to start. We have been very fortunate this morning.

So, Dr. Melnick.

**STATEMENT OF DANIEL MELNICK, Ph.D., ACTING DIRECTOR,
OFFICE OF APPLIED STUDIES, SUBSTANCE ABUSE AND MENTAL
HEALTH SERVICES ADMINISTRATION**

Dr. MELNICK. Thank you very much, Mr. Chairman, and I really appreciate this hearing a lot. I have felt that I have learned a lot from it myself, and I want to commend you for holding it.

I would like to say that I have a prepared statement and I would like to include it in the record. I have also submitted to the committee copies of reports that we have done which provide a lot of detail for what I am going to be talking about together with the methodology and limitations, and in the interests of time I would like to ask that they also be included at least in the official record of the hearing.

[The information referred to may be found in the subcommittee files.]

Mr. CONDIT. Absolutely.

Mr. MELNICK. At this time I would like to also say that two key people from my office are in the room, Mr. Joseph Gfroerer and Janie Dargan, who play key roles in doing this work, and they would be available. If we run into a very technical detailed question, I may call on them.

The Office of Applied Studies was established in 1992 at the time when SAMSA came into existence. OAS works to generate information which the public can use to understand and address issues and problems relating to addictive disorders. This morning I am going to talk about data from two of our studies, the National Household Survey on Drug Abuse and the Drug Abuse Warning Network.

I might say that both of these studies came to us as a result of the reorganization and were originally worked on in NIDA, and I would note that Zili Sloboda who is sitting next to me was a key person at an earlier stage.

The National Household Survey on Drug Abuse is the largest periodic survey of the general population which asks about drug use, treatment, problems, and conditions. As with all general population surveys, this one has a difficult time reporting on relatively rare events and small groups of people such as people who use illicit drugs, but we make extraordinary efforts to get the most complete and accurate results.

This morning I will be reporting on the results from our surveys up to 1992. The 1993 report will be out shortly and will be provided to the committee when it comes out.

OAS also runs the Drug Abuse Warning Network which includes a nationally representative sample survey of hospital emergency rooms as well as a selected set of medical examiners. We report results for the Nation as a whole and 21 metropolitan areas separately.

In the emergency rooms of more than 500 hospitals, we review medical records to count emergency room visits caused by the use of illicit drugs or the nonmedical use of legal drugs. Medical personnel of participating hospitals help us greatly to locate such cases and to make sure that the recording of information about them is accurate. The results from DAWN show the number of cases, not the number of people treated. The results show the harmful effects of substance abuse on our society.

Now let's review some of the recent and long-term trends indicated by these surveys for cocaine and heroin.

The National Household Survey on Drug Abuse has been tracking cocaine for more than 15 years. Chart 1 over here provides two perspectives on the use of cocaine in the United States during the 1970's, 1980's, and early 1990's. The solid red line at the top shows the number of people we estimate used cocaine in the past month in those years. It is based on surveys conducted from 1977 to 1992. It shows a dramatic growth in the number of persons using this drug between 1977 and 1985 and the subsequent decrease in use, approximately 1.6 million in 1977, 5.3 million in 1985, and then 1.3 million in 1992. The dotted yellow line shows the results of a study done by Joe Gfroerer of OAS and Mark Brodsky who actually works for Zili Sloboda, sitting next to me, of NIDA.

In their study, they examined information from the 1985 through 1991 surveys related to the year when persons reported that they first used cocaine—in other words, the inception of use. This analysis shows that while the number of current users was still growing in the early 1980's, the number of new users was beginning to decline, as you can see. At its peak in 1982, the number of new cocaine users reached 1.7 million persons in a single year.

Chart 2 shows trends in emergency room visits related to cocaine since 1978. These data from DAWN show a steep increase over the same period, each continuing after 1975 when the number of current users began to decline.

Now the point here is that the impact of starting to use cocaine persists over many years. Even as the number of new users declines, the number of current users continues to increase, and the ill effects on health are felt many years later.

Who are cocaine users? What groups of people use cocaine? Data from the household survey also helps us to identify groups of people who are most affected by drug abuse, and examination of these data shows that the picture we have of abusers is heavily influenced by the way we look at the data.

Chart 3 shows that while unemployed persons are more than twice as likely to use cocaine as employed persons, the majority of current cocaine users are employed and 55 percent of the current users are employed full time; only 17 percent of the current cocaine

users are unemployed, and chart 4 shows this information by ethnic group. It shows that Hispanics have the highest rates of cocaine use, and while African Americans have higher rates than whites, whites still constitute almost 66 percent of cocaine users, and I think it is very important to bear this thing in mind.

Now let's turn to heroin. Recently there have been reports that service providers, law enforcement officials, and/or practitioners have noticed increases in heroin cases related to problems. We submit that there may be three possible explanations for this increase: An increasing number of people using heroin, changes in the patterns of use, particularly the amount and purity to have drugs used by individuals, or the aging of the heroin population, making long-term users more prone to the ill effects of drug use. It is most likely that we are seeing a combination of these effects. Unfortunately we do not yet have clear evidence to determine the degree of this mix.

SAMSA, ONDCP, and others are working on developing new procedures to estimate the size of the user population or to track changes from year to year in a reliable fashion, but for the present we must face the fact that we have inadequate and only approximate measures of the number of users.

We do have much better information about the impact heroin abuse has on emergency medical care, and while not probative, this information is indicative of the general pattern of change. SAMSA's DAWN survey of emergency rooms provides evidence of increased consequences of heroin. The survey shows that emergency room cases caused by heroin abuse increased from about 29,000 in 1985 to about 48,000 in 1992. Recently there was a 34 percent increase in these episodes from 1991 to 1992. This increasing trends in 1993. We have already reported this for the first 6 months of 1993, and we are about to report it—further information about what happened in 1993 for the whole year very shortly, in a month or so.

DAWN data show the number of cases, not the number of people treated, as I said before. We believe that the number of heroin users in the Nation is actually somewhere between one-half million and 1 million persons. Dr. Kleber said he thought it was about 600,000. This means that, at most, the number of people showing up in emergency rooms is only 10 percent of the number who have problems.

Chart 5 presents DAWN data trends for heroin. It shows the growth of these cases among people over age 35. In 1992, 52.9 percent of the heroin cases involved people over age 35 compared with 15 percent, or about 16 percent, in 1978. In fact, 65 percent of the increase in heroin cases between 1978 and 1992 is due to increases in cases involving people over age 35.

The rise in heroin problems seems partly attributable to drug use that began several decades ago. AIDS plays some role in this, although it does not account for most of the increase in heroin cases, and there is more data about that in my prepared testimony.

Knowledge and attitudes play a critical role. The climate of opinion about drug use is a powerful force. The 1992 household survey on drug abuse shows that people who believe there is not a great risk of harm in trying cocaine are 4.7 times as likely to be current users as those who believe there is a great risk of harm. Those who

believe that cocaine is easy to get are 7.5 times as likely to be current users as those who do not believe cocaine is easy to get.

Thus, it is a matter of some concern that when asked about the availability of drugs 59.1 percent said that marijuana was easy to get, 40.2 percent said that cocaine was easy to get, 37 percent said that LSD was easy to get, 25 percent said that PCP was easy to get, about 27 percent said that heroin was easy to get. More people reported drugs were easy to get than actually ever used drugs; 59 percent said marijuana is easy to get, but only 36 percent ever used it; 40 percent said it is easy to get cocaine, but only 11 percent have ever used it.

Similarly, large numbers of people do not believe that using drugs is risky. The following percentages of the population do not find a great risk of harm of smoking marijuana occasionally, 55 percent; trying cocaine once or twice, 32 percent; trying heroin once or twice, 25 percent; smoking one or more packs of cigarettes a day, for comparative purposes here, 36 percent.

SAMSA and the OAS will continue to work hard in cooperation with our sister agencies to develop new measures of these critical conditions and to report them to you and to the public. In this way we can continue to develop the most effective and appropriate treatment and prevention programs which address the substance abuse problems of the Nation.

I greatly appreciate the opportunity to present this testimony. I will be happy to respond to any questions that you may have.

[The prepared statement of Dr. Melnick follows:]

TESTIMONY

OF

DANIEL MELNICK, PH.D.
ACTING DIRECTOR

OFFICE OF APPLIED STUDIES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
PUBLIC HEALTH SERVICE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

COMMITTEE ON GOVERNMENT OPERATIONS
SUBCOMMITTEE ON INFORMATION, JUSTICE, TRANSPORTATION AND AGRICULTURE

U.S. HOUSE OF REPRESENTATIVES

ON

"CURRENT DRUG USE TRENDS"

May 25, 1994
Room 2203 Rayburn House Office Building

FOR RELEASE UPON DELIVERY ONLY

Good morning Mr. Chairman and members of the Subcommittee.

I am Daniel Melnick, Acting Director of the Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA). I am very pleased to be here testifying on data concerning drug use trends in our nation. For your information, I have provided the Subcommittee with copies of Advance Reports recently prepared by our office. They present the details of the results and procedures being discussed this morning and I ask that they be made a part of the record along with my testimony.

The Office of Applied Studies (OAS) was established in 1992 at the time SAMHSA came into existence. OAS works to generate information which Congress, the Executive Branch, State and local policy makers, the field and the public can use to understand and address the issues and problems related to addictive disorders.

This morning, I am going to talk about data from the National Household Survey on Drug Abuse (NHSDA) and the Drug Abuse Warning Network (DAWN).

NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE (NHSDA)

The National Household Survey on Drug Abuse (NHSDA) is the largest periodic survey of the general population which asks about drug use, treatment, problems and conditions. In 1994, we are collecting about 20,000 interviews for this survey. From 1991 to 1993 about 30,000 people were interviewed each year, giving us a file of about 90,000 cases which we are going to analyze as a single source of baseline data on conditions in those years. We are also adding information on the neighborhoods in which people live from a variety of different data sources, including: the census, justice system records, treatment services, and other sources. The focus of this work is to build a set of regular indicators which will not only track trends over time but will also help us to better understand the problems of substance abuse.

It is important to understand the limits of this survey. All general population surveys have a difficult time reporting on relatively rare events and small groups of people. These surveys are designed to represent the whole population, and thus have difficulty focussing on special groups.

This morning I will be reporting on data from our surveys up to 1992. The 1993 results will be released this summer.

DRUG ABUSE WARNING NETWORK (DAWN)

OAS also conducts the DAWN survey. This survey is a comprehensive system for tracking new substances and provides a running account of the impact of the drug problem. This project includes a nationally representative sample survey of hospital emergency rooms as well as a selected set of medical examiners. We report results for the Nation as a whole and 21 metropolitan areas.

In the emergency rooms of more than 500 hospitals, medical records are read to determine which patients visited the emergency room due to a problem caused by the use of illicit drugs or the non-medical use of legal drugs. When using results from DAWN, it is important to understand that the data show the **number of cases**, not the number of people treated. Therefore, it is difficult to go from the results reported in DAWN to statements about the number of people using drugs. Increases might reflect an increased number of users, more harmful patterns of use, the aging of the drug using population or a combination of factors. However, the results are still an important indicator of the harmful effect of substance abuse on our society.

CURRENT CONDITIONS AND LONG TERM TRENDS

Next, I will review some of the recent and long term trends indicated by these surveys for cocaine and heroin.

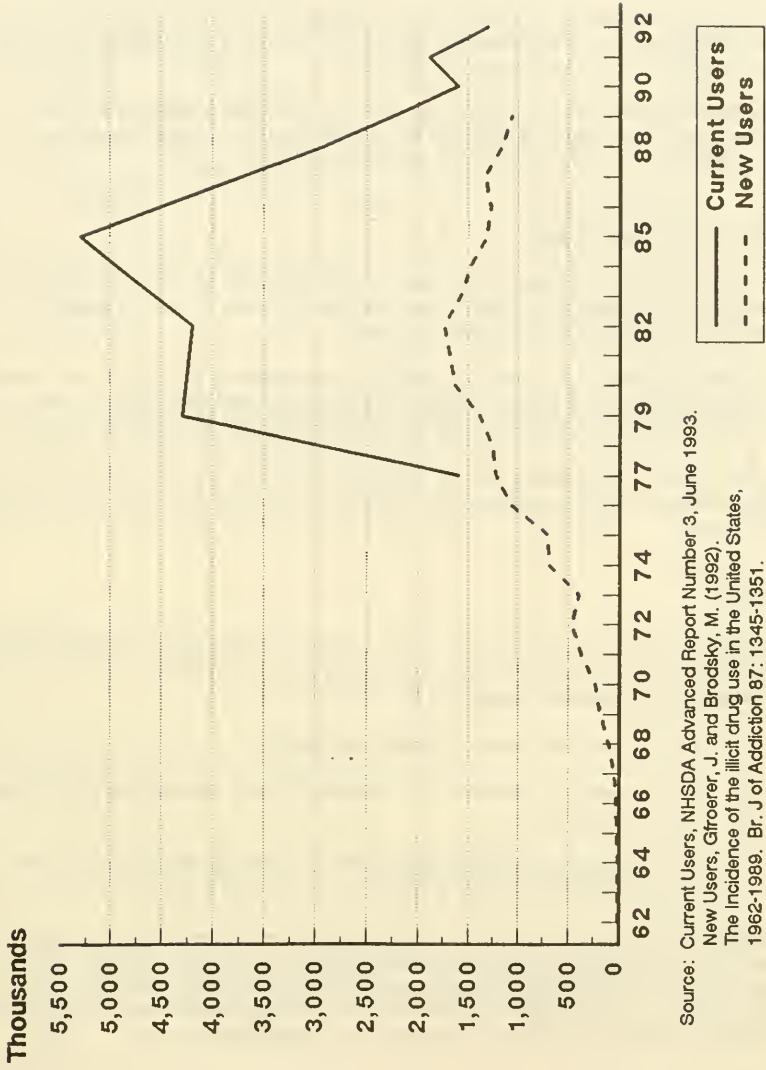
Cocaine

The National Household Survey on Drug Abuse has been tracking cocaine use for more than 15 years.

Chart I provides two perspectives on the use of cocaine in the U.S. during the 1970's, 1980's and early 1990's. The solid line shows the number of people we estimate used cocaine in the month before they were interviewed during this period. It is based on the repeated surveys conducted from 1977 to 1992. It shows a dramatic growth in the number of persons using this drug between 1977 and 1985, and a subsequent decrease in use: approximately, 1.6 million in 1977, 5.3 million in 1985, and then 1.3 million in 1992.

The dotted line shows the results of a study done by Joseph Gfroerer of OAS and Marc Brodsky of NIDA. In their study they took information from the 1985 through 1991 surveys related to the year when persons reported they first used cocaine. This analysis shows that while the number of current users was still growing in the early 1980s, the number of new users was beginning to decline. At its peak in 1982, the number of new cocaine users reached 1.7 million persons.

I. Cocaine Users



Source: Current Users, NHSDA Advanced Report Number 3, June 1993.
New Users, Gfroerer, J. and Brodsky, M. (1992).
The incidence of the illicit drug use in the United States,
1962-1989. Br. J of Addiction 87: 1345-1351.

Chart II shows trends in emergency room visits related to cocaine since 1978. These data from DAWN show a steep increase over the same period, even continuing after 1985 when the number of current users began to decline.

The important point here is that the impact of starting to use cocaine persists over many years. Even as the number of new users declines, the number of current users continues to increase and the ill effects on health are felt many years later.

Who Are the Cocaine Users?

Data from the Household Survey also helps us to identify people who are most affected by drug abuse. An examination of these data shows that the picture we have of abusers is heavily influenced by the way we look at the data.

Chart III shows that while unemployed persons are more than twice as likely to use cocaine as employed persons, the majority of current cocaine users are employed and 55% of them are employed full time. Only 17.1% of the current cocaine users are unemployed.

Chart IV shows that Hispanics have the highest rates of cocaine use. And, while African Americans have higher rates than whites, whites constitute almost 66% of the cocaine users in the Nation.

Heroin

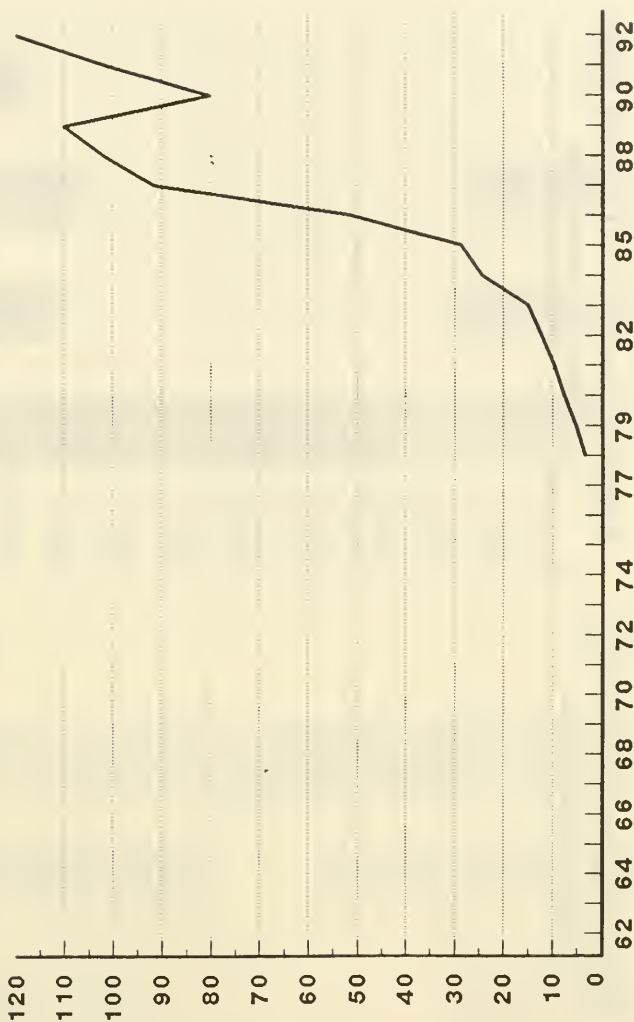
Recently, there have been reports that service providers, law enforcement officials and other practitioners have noticed increases in heroin cases and related problems. We submit that there may be three possible explanations for this increase:

- * an increasing number of people using heroin;
- * changes in the patterns of use, particularly the amount and purity of drugs used by individuals; or
- * the aging of the heroin using population making the long term users more prone to the ill effects of drug use.

We think it is most likely that we are seeing a combination of these effects. Unfortunately, we do not yet have clear evidence to determine the degree of this mix. SAMHSA, ONDCP and others are working on developing new procedures to estimate the size of the user population or to track changes from year to year in a reliable fashion. But, for the present we must face the fact that we have inadequate and only approximate measures.

II. DAWN Cocaine Episodes

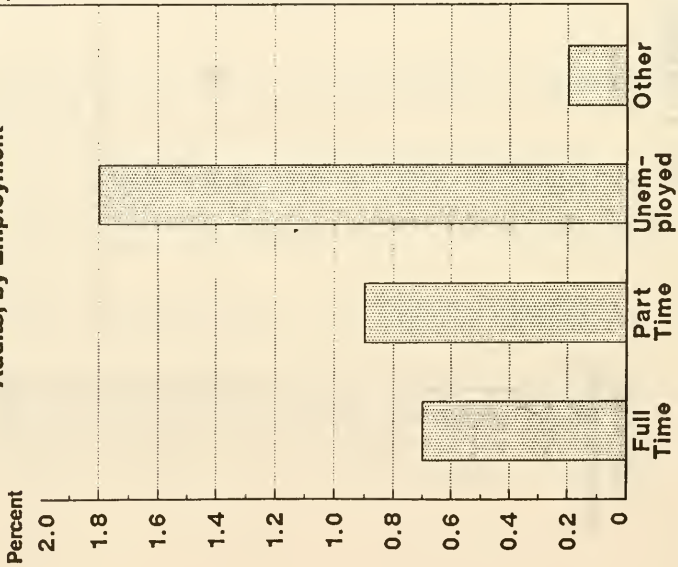
Episodes
(in thousands)



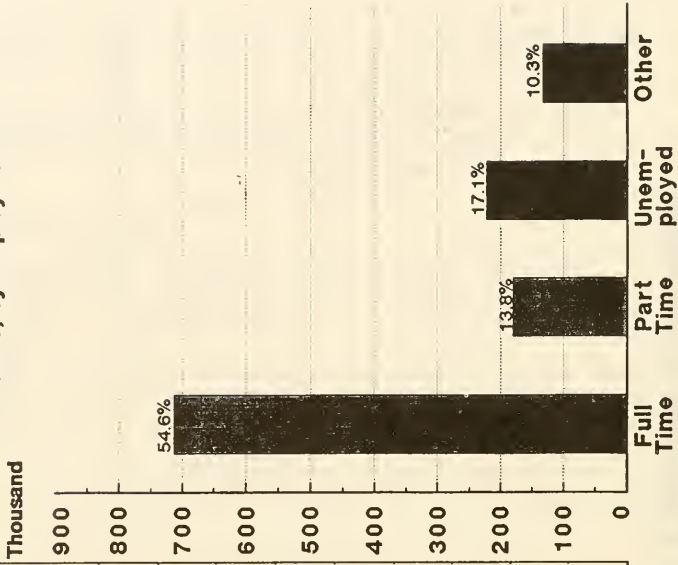
Source: SAMHSA, DAWN Advanced Report Number 4, September 1993

III.

Prevalence of Cocaine Use Adults, by Employment



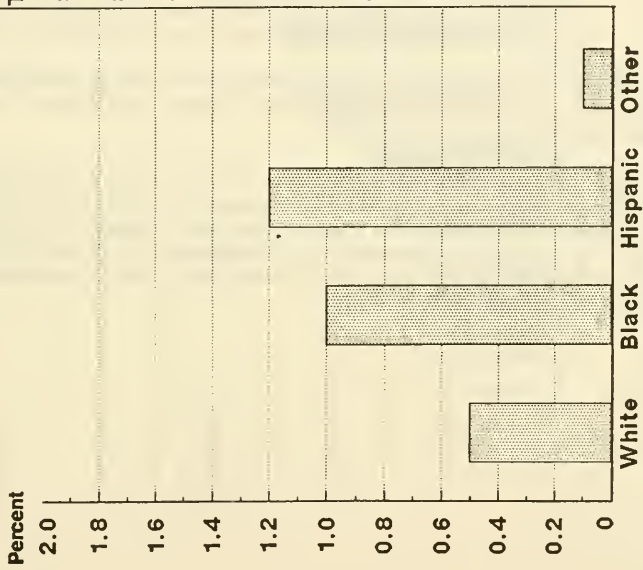
Relative Proportion of Cocaine Users Adults, by Employment



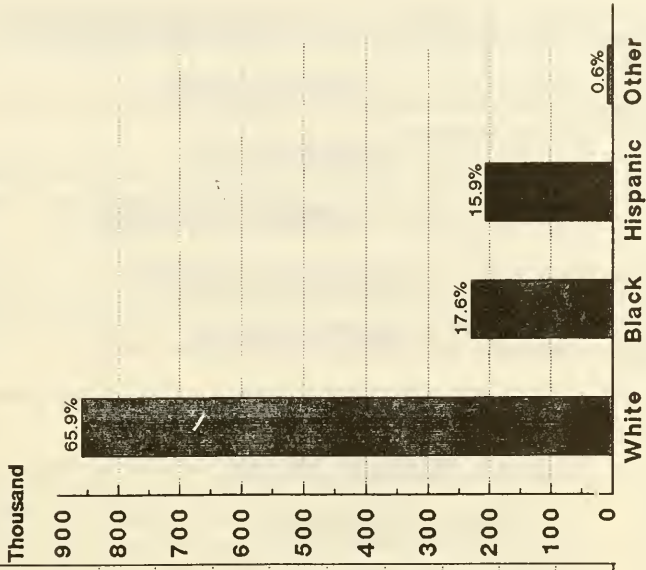
Source: SAMHSA, National Household Survey on Drug Abuse, Advanced Report Number 3, June 1993

IV.

**Prevalence of Cocaine Use
by Race / Ethnicity**



**Relative Proportion of Cocaine Users
by Race / Ethnicity**



Source: SAMHSA, National Household Survey on Drug Abuse, Advanced Report Number 3, June 1993

We do have much better information about the impact heroin abuse has on emergency medical care. And while not probative, this information is indicative of the general pattern of change.

SAMHSA's DAWN survey of emergency rooms provides evidence of increased consequences of heroin. The survey shows that:

- * Emergency room cases caused by heroin abuse increased from 29,000 in 1985 to 48,000 in 1992. Recently, there was a 34 percent increase in these episodes from 1991 to 1992. This increasing trend continues in 1993.

It is important to remember that the data show the number of cases, not the number of people treated. We believe that the number of heroin users in the nation is actually somewhere between 500,000 and 1 million. This means that at most the number of people showing up in emergency rooms is only 10 percent of the number who have problems.

Chart V presents DAWN data which indicates that recent emergency room patients over the age of 35 and admitted for heroin related episodes, have increased:

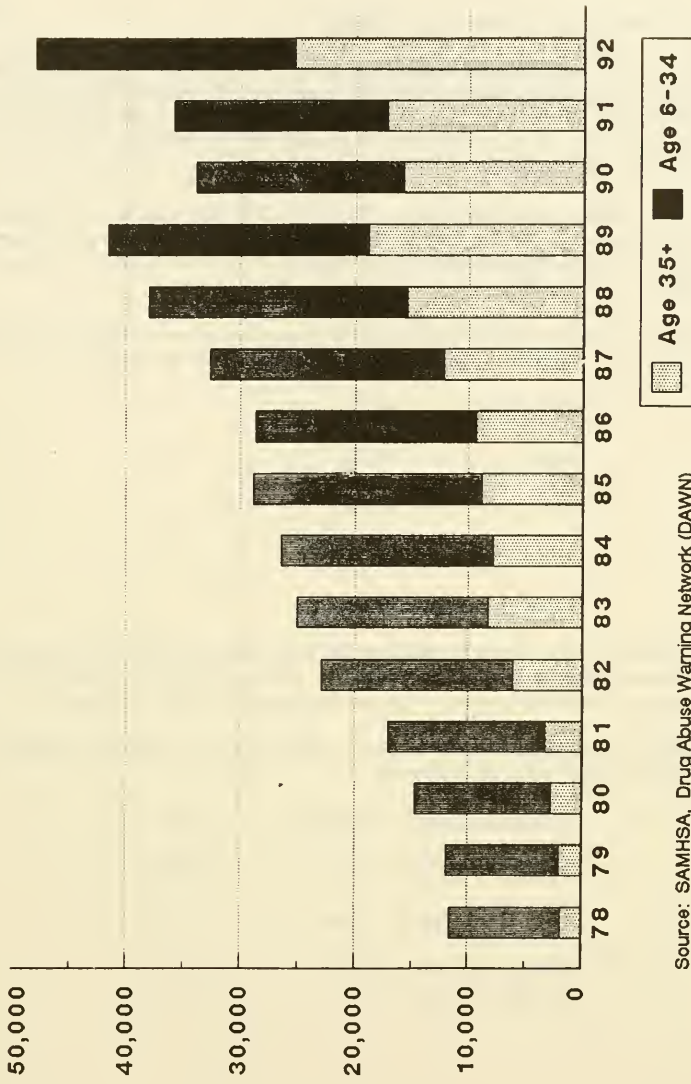
- * In 1992, 52.9% of the heroin cases involved people over age 35 compared with 15.8% in 1978. In fact, 65% of the increase in heroin cases between 1978 and 1992 is due to the increase in cases involving people over age 35. (The number of heroin related cases involving people age 35 and older grew from 1,800 in 1978 to 25,000 in 1992. At the same time, the number of heroin cases involving those younger than age 35 grew from 9,800 to 23,000.)

Thus, the rise in heroin problems seems partly attributable to drug use that began several decades ago, has continued, and is now presenting in hospitals with the related health problems by this long term user population.

AIDS plays some role in this, although it does not account for most of the increase in heroin cases. For example, between 1990 and 1992, the number of heroin episodes among those age 35 or older in which the patient was reported to have AIDS increased by about 1,600, from 422 to 2,128. However, this represents only a small proportion of all the heroin-related episodes for that age group. Overall, episodes among the 35 and older population increased by almost 10,000, from 15,850 to 25,376.

V. Total Heroin / Morphine Episodes by Age, 1978 - 1992

Episodes



Source: SAMHSA, Drug Abuse Warning Network (DAWN)

The Critical Role of Knowledge and Attitudes

The climate of opinion about drug use is a powerful force. The 1992 Household Survey also shows that people who believe there is not a great risk of harm in trying cocaine are 4.7 times as likely to be current users as those who believe there is a great risk of harm. Those who believe that cocaine is easy to get are 7.5 times as likely to be current users as those who do not believe that cocaine is easy to get.

Similarly, those who believe there is not a great risk of harm from using marijuana are 9.1 times as likely to be current users as those who believe there is a great risk of harm; while those who believe that marijuana is easy to get are 4.7 times as likely to use it as those who believe its not easy to get.

Thus, it is a matter of some concern that when asked about the availability of drugs, the following percentage of the population reported they were it was easy to get:

*	Marijuana	59.1%
*	Cocaine	40.2%
*	LSD	27.2%
*	PCP	24.7%
*	Heroin	26.5%

An interesting note: These figures show that more people reported drugs were easy to get than actually ever used drugs. 59 percent say Marijuana is easy to get but only 36 percent ever used it. 40% say it is easy to get cocaine but only 11% have ever used it.

Similarly, when we asked about the risk of using drugs, the following percentages of the population found great risk of harm in:

*	Smoking Marijuana Occasionally	44.9%
*	Trying Cocaine Once or Twice	68.4%
*	Trying Heroin Once or Twice	75.2%
*	Smoking one or more packs of Cigarettes per day	64.1%

CONCLUSION

SAMHSA and the OAS will continue to work hard and in cooperation with our sister agencies to develop new measures of these critical conditions and to report them. In this way we can continue to develop the most effective and appropriate prevention and treatment programs which address the substance abuse problems in the Nation.

Thank you for this opportunity. I will be happy to respond to any questions Subcommittee members may have.

Mr. CONDIT. Thank you Dr. Melnick. You were very kind to move very quickly, and I appreciate it.

Ms. Sloboda, how much time do you think you are going to—

Ms. SLOBODA. Ten minutes.

Mr. CONDIT. All right. Let's try to do it before we vote.

STATEMENT OF ZILI SLOBODA, ACTING DIRECTOR, DIVISION OF EPIDEMIOLOGY AND PREVENTION RESEARCH, NATIONAL INSTITUTE ON DRUG ABUSE

Ms. SLOBODA. Good afternoon. Thank you very much for inviting me here.

I am the acting director of the Division of Epidemiology and Prevention Research at the National Institute on Drug Abuse. The broad objectives of the division's program are to understand the factors and processes that explain variations in drug use and abuse patterns and behaviors and to identify effective strategies for preventing these behaviors.

I therefore am very appreciative of being asked to discuss emerging trends in drug abuse today, particularly trends among youngsters who are the future of the United States.

My testimony today is an overview of drug abuse trends based on data from monitoring the future study, commonly referred to in the past as the high school senior survey. I will deviate somewhat from my prepared testimony, and I am submitting—requesting that they both be entered in the record.

Reference has been made among prior panelists to these data, and I am going to be giving you more detailed information on the survey. I will tell you about increases in the use of marijuana in grades 8, 10, and 12, in the use of LSD in high school seniors, and inhalant use in eighth graders, and the use of cocaine and crack. Cocaine has stabilized at about 3 and 1.5 percent, respectively.

It is important to note that increases have also occurred in the use of tobacco and alcohol which have been termed gateway drugs by drug abuse researchers and practitioners. We should also remember that even when illicit drug use was at its lowest levels among adolescents a couple of years ago, we were still talking about almost 1 million youngsters who were at risk because they had initiated drug use.

There still remains the need for the diffusion of scientifically supported, effective prevention strategies and drug abuse treatment programs and for the assurance of the quality of these services as well as for research that explores the factors associated with the initiation of drug use and progression to abuse and dependence.

The monitoring the future study was launched in 1975 under the auspices of NIDA and the Special Action Office on Drug Abuse Policy in recognition of the need for national data to measure the emerging drug abuse situation. Since then, the project has been funded by NIDA through a series of competing research grants. The monitoring the future study is designed to track changes in the life styles, values, and preferences of American youth.

Because the study collects data on age groups in which drug use is initiated, it comes closer than other national data systems to measuring incidence. For that reason, the monitoring the future project provides an invaluable early warning of impending drug

problems that can be used for prevention and early intervention planning as well as for etiologic and epidemiologic research.

In the spring of each year since 1975, researchers at the University of Michigan's Institute for Social Research have collected data from high school seniors at a representative sample of public and private schools throughout the Nation. Since 1991, monitoring the future also has included samples of eighth and tenth graders similar to the samples of senior year students. By adding these younger students, monitoring the future has extended its coverage to include students who may later drop out of school, a group at high risk of drug abuse.

In 1993, monitoring the future survey collected data from 16,763 high school seniors from 139 schools, 15,516 tenth graders from 128 schools, and 18,820 eighth graders from 156 schools.

After a peak in drug use experienced between 1978 and 1981, there has been a consistent decline in reports of illicit drug use among American high school seniors to a low of 40.7 percent in lifetime use reported for the class of 1992. That is almost 1 million youngsters. Marijuana accounted for most of this illicit drug use.

The decline in marijuana use has been associated with increased perceptions of the negative consequences of the use of marijuana and with increased perceptions by youngsters that such use is disapproved by their peers.

However, the findings of the 1993 monitoring the future survey revealed that the percentage of young people who report using drugs, cigarettes, and/or alcohol either increased or remained level from 1992 to 1993.

I would like to briefly mention the changes that have been reported in 1993 for high school seniors and eighth and tenth graders. Any change I will be discussing in this section is statistically significant. However, I would like to caution that in the context of long-term trends 1993 is the first year the trend has changed. Further data will be needed to determine whether direction of the long-term trend has shifted.

I had taken out from the packet of your materials two graphs that I may refer to. The first one looks at the marijuana trends for these different grades, and you can see that increases between 1992 and 1993 surveys have been noted for marijuana across all three grades in all prevalence measures, lifetime, annual, and current use.

In 1993 approximately 624,000 seniors, 576,000 tenth graders, and 276,000 eighth graders used marijuana at least once in the year prior to the survey. Inhalants tend to be used by younger children, and increased use was observed for eighth graders between 1992 and 1993. The annual prevalence of LSD use among seniors, 6.8 percent, is reaching the level of greatest use in 1975, which was 7.2 percent.

These increases in marijuana use have been observed across the United States in the northeastern, north central, and southern States, in large cities and small cities, as well as outside metropolitan areas, among African Americans and whites, but not Hispanic students, and across all social classes.

Increases in LSD use among seniors occurred in all regions in all areas regardless of urbanicity and in all social classes and among African American and white students.

In the second graph I will show you, you can see that these changes in drug use are associated with changes in attitudes. That is to say, fewer youngsters are reporting negative perceptions about the use of drugs. From our experience over the past 19 years, we expect that continuing tolerance of drug use will lead to increases in these behaviors, and I wanted to point out—that is not on this chart—that these drug use measures and these perceptions are against a background where 83 percent of seniors believe that they can access marijuana easily.

The results I have just presented relate to illicit drug use. However, the survey has shown that significant changes have occurred for daily use of cigarettes for all grades, and for alcohol for the 10th and 12th grades. There is sufficient evidence from longitudinal studies of youngsters to show the relationship between the early use of tobacco and cigarettes and later use of marijuana and other drugs.

As you can see, the findings of the 1993 monitoring the future study show reason for concern. Rates of drug use are up in a number of categories for all three grades. These increases along with the changes in attitudes about drug use should alert us to possible increases in the use of drugs in the next few years. The key questions are, why is this happening and what can we do about preventing further increases?

NIDA's supported longitudinal research has shown that both the use of cigarettes, alcohol, and illicit drugs among youngsters does not occur precipitously but is the result of a long-term process. The increases in drug use today are the results of several distal as well as proximal factors. Many hypotheses have been put forth by drug abuse prevention experts. These include an observation that there has been a general rise in deviance in the United States.

Indeed, monitoring the future survey reports that rates of delinquency among high school seniors has reached their highest level since 1975. In addition, the early use of the gateway drugs has increased among young people, and with the negative images of tobacco products, their use may now be considered deviant.

Finally, the changing attitudes which we have heard mentioned many times today about drug use may be related also to a movement to glorify drug use, to a decreased depiction of the negative aspects of drug abuse in the media, and to adult use of drugs, including parents who were teenagers during a time that was more tolerant of drug use.

Thank you, Mr. Chairman. I would be pleased to answer any questions you have.

[The prepared statement of Ms. Sloboda follows:]

Testimony for Zili Sloboda, Sc.D.
Acting Director
Division of Epidemiology and Prevention Research
Before the House Subcommittee on
Information, Justice, Transportation & Agriculture
on
Illegal Use of Narcotics in United States
May 25, 1994

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Statement of the Acting Director
Division of Epidemiology and Prevention Research
National Institute on Drug Abuse

Mr. Chairman and members of the Subcommittee, I am Dr. Zili Sloboda, Acting Director of the Division of Epidemiology and Prevention Research at the National Institute on Drug Abuse (NIDA). The broad objectives of the Division's program are to understand the factors and processes that explain variations in drug use and abuse patterns and behaviors and to identify effective strategies for preventing these behaviors. Since drug abuse is an important health problem in its own right and a significant cause of many other diseases, the tools of modern epidemiology are essential for its understanding, its prevention, and its treatment.

Current initiatives under our program encompass many areas of study, including, but not limited to, etiological and prevention intervention research focusing on subpopulations such as minorities, females, and the underserved; biobehavioral research; research on factors associated with the initiation of drug use and escalation to abuse and dependence; expansion of community epidemiology research studies; development of techniques to improve the reliability and validity of information on drug using behaviors; expanded studies of drug using behavior in rural populations; and research on the economic, social, and health consequences of drug abuse.

Over the years, one of the Division's most visible achievements has involved tracking the incidence and prevalence of drug use among adolescents, a group often on the leading edge of societal change. My testimony will provide an overview of drug use trends in this population, based on data from the Monitoring the Future Study, commonly referred to in the past as the High School Senior Survey.

BACKGROUND

The Monitoring the Future Study is intended to assess the changing lifestyles, values, and preferences of American youth on a continuing basis. Launched in 1975 under the auspices of NIDA and the Special Action Office on Drug Abuse Policy (SAODAP), Monitoring the Future was designed to meet the need for data to measure the emerging drug abuse situation among the Nation's youth. Since then, the project has been funded by NIDA through a series of competing research grants.

Each year since 1975, between 15,000 and 19,000 senior year students from a representative sample of 123 to 138 public and private high schools have participated in this survey. The 1993 survey is the third year that comparable samples of both eighth and

tenth graders were also surveyed. This survey is conducted under a grant sponsored by NIDA with an annual cost of approximately \$3 million. The principal investigator is Lloyd Johnston, Ph.D. from the University of Michigan's Institute for Social Research (ISR). Data from eighth, tenth, and twelfth graders in the coterminous United States are collected during the spring of each year.

Schools are selected in such a way that half of each year's sample is comprised of schools which participated the previous year and half is comprised of schools which will participate the next year. This design improves year-to-year statistical comparisons. Each year, approximately 66 to 80 percent of the schools agree to participate. A replacement procedure is used for the other 20 to 34 percent that choose not to participate. Substitute schools are selected to closely match the refusals according to their similarity on several criteria (e.g. geographic area, similar neighborhoods, similar size and demographic composition, etc.).

Beginning with the graduating class of 1976, a subsample of each class has been followed up annually on a continuing basis. A representative sample of 2,400 individuals is chosen for follow-up. In order to ensure sufficient numbers of drug users in the follow-up surveys, seniors reporting current drug use are selected with a higher probability. Each year since 1980, the study has been able to report on drug use among American college students.

The latest Department of Education statistics indicate that in 1990, there were 2.4 million seniors, 2.9 million tenth graders, and 3.0 million eighth graders enrolled in United States schools.

1993 PARTICIPANTS

The 1993 survey was the 19th in the series and surveyed 16,763 high school seniors, 15,516 tenth graders, and 18,820 eighth graders. For the high school seniors, there were a total of 139 schools in the survey, there were 128 schools for the tenth graders and 156 schools for the eighth graders. The response rate for seniors was 84 percent, 86 percent for tenth graders, and 90 percent for the eighth graders.

PREVALENCE ESTIMATES

Data are presented as the proportion of seniors, tenth graders, or eighth graders who have used the selected substances (expressed as a percentage), rather than the numbers of students who have used the specific substance.

DEFINITIONS OF DRUG USE

Prevalence Measures:

- Lifetime - percent who used at least once in their lifetime
- Past Year (Annual) - percent who used at least once in the 12 months prior to the survey
- Past Month (Current Use) - percent who used at least once in the thirty days prior to the survey
- Daily - percent who used twenty or more times in the thirty days prior to the survey (except for cigarettes, where the definition is one or more cigarettes per day in the thirty days prior to interview)

Types of Drugs Reported in Survey:

- | | |
|---|--|
| o Any Illicit Use
(calculated for seniors only) | o Other opiates (i.e. morphine,
codeine, etc) |
| o Marijuana/Hashish | o Stimulants |
| o Inhalants; also
Amyl & Butyl Nitrites
(seniors only) | o Crystal Methamphetamine
(seniors only) |
| o Hallucinogens; also
LSD, PCP and
Hallucinogens other than LSD | o Sedatives; also
Barbiturates, Methaqualone
(seniors only on all) |
| o Cocaine
Crack, other cocaine | o Tranquilizers |
| o Heroin | o Alcohol |
| o Steroids | o Cigarettes |

DESCRIPTION OF DATA PRESENTED

The attached tables contain estimates of drug use among eighth, tenth, and twelfth graders. Long term trend estimates (from 1975 to 1993) are available for seniors only. Three years of data (1991 through 1993) are now available for eighth and tenth graders.

All differences discussed are statistically significant.

DATA LIMITATIONS AND STATISTICAL SIGNIFICANCE OF ESTIMATES

When producing estimates from any sample survey, two types of errors are possible -- sampling and nonsampling error. The sampling error of an estimate is the error caused by the selection of a sample instead of a census. Sampling error is reduced by selecting a large sample or by using efficient sample design and estimation strategies. Nonsampling errors include such things as nonresponse and reporting errors. Nonsampling errors are reduced through data editing, periodic re-training of field staff, and other quality control procedures.

Statistical significance does not always imply that the difference is large or important. What it does imply is that one can conclude (with a small chance of being incorrect) that if a census was conducted, the population prevalence values would have changed over the time periods in question. A change that is not statistically significant may result from random fluctuations in the estimates due to selecting a sample of students instead of a census.



SUMMARY STATEMENTS FOR the 1993 MTF

- o Data from the 1993 survey reveals that, for the most part, the percentage of young people who report using drugs, cigarettes and/or alcohol is either level or increasing. Although there were only a few declines reported across all grades and substances, the percentage of seniors reporting the daily use of smokeless tobacco or daily use of alcohol decreased and the percentage of tenth graders reporting past month use of tranquilizers declined. Also, the percentage of eighth graders reporting lifetime use of smokeless tobacco dropped.
- o After declining steadily from the peak years around 1979, current use, past year use, and lifetime use of any illicit drug by seniors increased between 1992 and 1993. (A large part of the any illicit drug category is marijuana/hashish). Since this is the first year the trend has changed, results should be interpreted with caution.
- o After decreasing between 1991 and 1992, the current use, past year use, and lifetime use of marijuana/hashish by high school seniors graduating in 1993 all experienced increases between 1992 and 1993.
- o From 1992 to 1993, there were increases in the proportions of eighth and tenth graders reporting lifetime, annual and past month use of marijuana/hashish. There was even an increase in the daily use of marijuana/hashish for eighth and twelfth graders during this time period.
- o With the notable exception of inhalants, the likelihood of using drugs generally increases with grade. Eighth graders, who had the largest increases between 1992 and 1993 in lifetime and past year use of inhalants, were more likely than the two older student groups to report using inhalants.
- o As compared to 1992, fewer students in all three grades thought that people who smoke marijuana occasionally or even smoke marijuana regularly potentially pose great harm to their health in 1993. Fewer eighth and tenth graders thought that people who try marijuana pose great harm.
- o In 1993, all three grades had fewer students who reported thinking that people greatly risk harming themselves when they try crack cocaine.
- o In 1993, fewer seniors thought that cocaine would be easy to obtain. However, more seniors thought it would be easy to get LSD and MDMA (ecstasy).

SUMMARY STATEMENTS FOR the 1993 MTF (continued)

- o There were no statistically significant differences in cocaine prevalence between 1992 and 1993.
- o Between 1992 and 1993, the percentage of tenth graders who reported **being drunk** at least once in the 30-days prior to survey increased from 18.1 percent to 19.8 percent. The proportion of tenth graders reporting **daily drinking** increased from 1.2 percent in 1992 to 1.6 percent in 1993.
- o More seniors and tenth graders reported **current smoking** in 1992 than in 1993. The 1993 numbers were 24.7 percent of the tenth graders and 29.9 percent of the seniors. More notably, **daily cigarette smoking** increased for all three student groups in 1993. The proportion of students reporting **daily smoking** ranged from 8.3 percent of eighth graders to 19.0 percent of the seniors.
- o Data from the 1993 survey show that large numbers of students in all three grades continue to report binge drinking (five or more drinks in a row within the two weeks prior to survey). Over one in eight (13.5 percent) 8th graders, 23.0 percent of 10th graders, and 27.5 percent of seniors report at least one occasion of binge drinking. Binge drinking only increased significantly for tenth graders between 1992 and 1993. (However, over time there has been a gradual reduction in so-called "binge drinking" among seniors, from 41.4 percent in 1981 (peak) to 27.5 percent in 1993).
- o In 1993, **daily use of alcohol** increased to 1.6 percent of tenth graders (compared to 1.2 percent in 1992), decreased to 2.5 of seniors (down from 3.4 percent in 1992), and remained unchanged among eighth graders.

LIFETIME PREVALENCE OF DRUG USE

Change in percentages between 1992 and 1993 (8th, 10th, and 12th graders)

- o As compared to 1992 survey results, increased proportions of eighth, tenth, and twelfth graders reported using some type(s) of illicit drugs at least once in their lives in the 1993 survey.
- o As compared to 1992, more eighth graders reported using inhalants at least once in their lives in 1993. This increase for the youngest students widens the gap between the older and younger students. In 1993, 17.4 percent of the seniors had used inhalants at least once in their lives compared to 19.4 percent of the eighth graders.
- o Lifetime use of marijuana/hashish by eighth, tenth and twelfth graders increased between 1992 and 1993. For seniors, lifetime use went from 32.6 percent in 1992 to 35.3 percent in 1993. In this same time period, the proportion of tenth graders reporting use went from 21.4 percent to 24.4 and the proportion of eighth graders increased from 11.2 to 12.6 percent who used marijuana/hashish at least once in their lives.
- o Lifetime use of LSD increased for seniors, from 8.6 percent saying they had used this drug at least once in their lives in 1992 to 10.3 percent in 1993. Lifetime use of any hallucinogens also increased for seniors, but is related to the increase for the use of LSD, which is a major component of the hallucinogen drug category.
- o The percentage of tenth graders having used stimulants at least once in their lives increased from 13.1 in 1992 to 14.9 percent in 1993.

Long Term Trends (Seniors only)

- o After peaking in 1981 (65.6%) and steadily declining to a low of 40.7 percent in 1992, the lifetime use of any illicit drug increased to 42.9 percent for the class of 1993.
- o Longer-term declines reversed for the lifetime use of many illicit drugs. Between 1992 and 1993, increases occurred for the use of marijuana/hashish, any hallucinogens and LSD. It should be noted that PCP, which is also a component of the hallucinogen drug category, remained virtually unchanged since 1990.

ANNUAL PREVALENCE OF DRUG USE

Change in prevalence estimates between 1992 and 1993 (8th, 10th, and 12th graders)

- o Past year use of **marijuana/hashish** by eighth, tenth and twelfth graders increased between 1992 and 1993. For both seniors and tenth graders, past year use increased 4 percentage points between 1992 and 1993. For seniors, past year use went from 21.9 to 26.0 in 1993 and for tenth graders, past year use increased from 15.2 percent in 1992 to 19.2 percent in 1993. In this same time period, the proportion of eighth graders reporting past year use of **marijuana/hashish** increased from 7.2 to 9.2 percent.
- o For seniors there was an increase from 5.6 to 6.8 percent saying they had used **LSD** at least once in the year prior to survey. Again, this increase contributed towards the increase for past year use in the **all hallucinogen** category by the class of 1993.
- o The percentage of tenth graders and seniors having used **stimulants** at least once in the past year increased between 1992 and 1993.
- o The percentage of seniors reporting having used **tranquilizers** at least once in the past year increased from 2.8 percent 1992 to 3.5 percent in 1993.
- o The use of **inhalants**-such as glues, aerosols, and solvents-is highest among eighth graders (11.0% of eighth graders reported past year use compared to 8.4% of tenth graders and 7.0% of seniors). Although all three student groups had increases between 1992 and 1993, only the eighth graders had a statistically significant increase.

Long Term Trends (Seniors only)

- o After steadily declining since 1979 (54.2%), the percent of seniors reporting past year use of **any illicit drugs** increased four percentage points from 27.1 percent in 1992 to 31.0 percent in 1993.
- o Between 1985 and 1992, the past year use of **hallucinogens** was reasonably level. Between 1992 and 1993, the categories of **all hallucinogens** and the subset category of **LSD** both experienced increases.
- o The proportion of seniors reporting past year use of **tranquilizers** peaked at 10.8 percent in 1977 and then declined steadily to a low of 2.8 percent in 1992. Between 1992 and 1993, this proportion increased to 3.5 percent.

PAST MONTH (CURRENT) USE

Change in prevalence estimates between 1992 and 1993 (8th, 10th, and 12th graders)

- o As seen with lifetime use and past year use, current use of any illicit drug increased between 1992 and 1993, rising from 14.4 percent to 18.3 percent for seniors (any illicit drug use is not calculated for 8th and 10th graders because the prevalence of some drugs are not available for the two lower grades).
- o Current use of **marijuana/hashish** by seniors, tenth graders and eighth graders increased in 1993. In 1993, 15.5 percent (a 3.6 percentage point increase) of seniors, 10.9 percent (a 2.8 percentage point jump) of sophomores, and 5.1 percent (a 1.4 percentage point increase) of eighth graders reported using this drug in the month prior to the survey.
- o The current use of **inhalants** increased for tenth graders, rising from 2.7 percent in 1992 to 3.3 percent in 1993.
- o Current use of **hallucinogens** increased for seniors in the class of 1993, rising from 2.1 percent in 1992 to 2.7 percent in 1993.
- o The percentage of seniors reporting current use of **stimulants** increased from 2.8 percent in 1992 to 3.7 percent in 1993.
- o For tenth graders, past thirty day use of **tranquilizers** decreased to 1.1 percent between 1992 and 1993.
- o More tenth graders reported being drunk at least once in the month prior to the survey in 1993 than in 1992 (19.8% and 18.1%, respectively). The proportion of tenth graders reporting **daily drinking** increased from 1.2 percent in 1992 to 1.6 percent in 1993.

Long Term Trends (Seniors only)

- o Current (past month) use of **marijuana/hashish** use peaked among seniors in 1978 (37.1%) and then declined steadily to a low of 11.9% for the class of 1992. This increased to 15.5 percent in 1993 (a 3.6% increase) is the first deviation from this trend in nine years.

ATTITUDINAL QUESTIONS ON DRUG USE

Change in percentages between 1991 and 1992 (8th, 10th, and 12th graders)

- o As compared to 1992, fewer students felt that persons are at great risk of harming themselves if they try marijuana (8th and 10th) smoke marijuana occasionally (8th, 10th and 12th) or smoke marijuana regularly (8th 10th and 12th).
- o Although the news on attitudes about perceived harm is mostly in the wrong direction in 1993, more 10th graders thought that persons trying inhalants or using them on a regular basis posed a great risk to their health.
- o There were disturbing decreases in the numbers of eighth, tenth and twelfth graders who felt that persons trying crack cocaine might be greatly risking their health. For the two younger student groups, there were fewer students saying that persons who occasionally use crack pose great risks to their health.
- o In 1993 fewer seniors, tenth or eighth graders reported disapproval of people who use marijuana. In the same year, fewer seniors and eighth graders reported disapproval of people using crack cocaine or cocaine powder.

An increased percentage of high school seniors reported perceived easy availability of LSD and MDMA (ecstasy) between 1992 and 1993.

- o On a more positive note, less tenth graders thought it would be easy to obtain steroids in 1993.

Long Term Trends (Seniors only)

- o Longer term trends in 12 graders' perceptions of the risks people assume when using drugs have generally been in the direction of more seniors believing that people greatly risk their health. However, in 1993, the number of seniors reporting that persons pose great risk to their health when they use any of several drugs declined significantly. Between 1992 and 1993, there was a statistically significant decrease in the number of seniors associating "great risk" for persons who use marijuana/hashish occasionally or regularly, try PCP once or twice, try crack cocaine, try cocaine powder, try crystal methamphetamine or use barbiturates regularly.

ALCOHOL AND CIGARETTES: PREVALENCE AND ATTITUDINAL DATA

Prevalence

- o A greater percentage of tenth graders reported smoking cigarettes at least once in their lives, rising from 53.5 in 1992 to 56.3 percent in 1993.
- o More seniors and tenth graders reported current smoking in 1992 than in 1993. The 1993 numbers were 24.7 percent of the tenth graders and 29.9 percent of the seniors. More notably, daily cigarette smoking increased for all three student groups in 1993, ranging from 8.3 percent of eighth graders reporting daily smoking to 19.0 percent of the seniors.
- o The only statistically significant decline for tobacco use in 1993 is a decrease in the daily use of smokeless tobacco use among seniors.
- o In 1993, daily use of alcohol increased to 1.6 percent of tenth graders (compared to 1.2 percent in 1992), decreased to 2.5 of seniors (down from 3.4 percent in 1992), and remained unchanged among eighth graders.
- o More tenth graders reported being drunk in the month prior to the survey in 1993 than in 1992 (19.8% and 18.1%, respectively).
- o Data from the 1993 survey shows that a large number of students in all three grades continue to report binge drinking (five or more drinks in a row within the two weeks prior to survey). Over one in eight (13.5%) 8th graders, 23.0 percent of 10th graders, and 27.5 percent of seniors report at least one occasion of binge drinking. Binge drinking only increased significantly for tenth graders between 1992 and 1993. (However, over time there has been a gradual reduction in so-called "binge drinking" among seniors, from 41.4 percent in 1981 (peak) to 27.5 percent in 1993).

Attitudes

- o Significantly fewer eighth graders reported thinking that it was easy to get either cigarettes or alcohol.
- o In the 1993 survey, significantly more tenth and twelfth graders felt that the regular use of smokeless tobacco might be harmful to their health as compared to 1992.
- o Only half (51.3%) of seniors from the class of 1975 thought that smoking one or more packs of cigarettes per day posed great risk of harm. Over the course of these annual surveys, this percentage increased to 68.6 percent for the class of 1987. Since then, perceived attitudes have not changed, and only 69.5 percent of the class of 1993 felt this level of smoking posed great risk of harm.
- o Only about half of the high school seniors perceive a great risk from drinking 5 or more drinks of alcohol once or twice a weekend. Slightly greater percentages of 8th and 10th graders judge this behavior as potentially harmful. There were no significant changes in these proportions between 1992 and 1993.

DEMOGRAPHIC AND GEOGRAPHIC DIFFERENTIALS IN DRUG USE

MTF trend data tabulated for a May 1994 ONDCP-sponsored meeting at the University of Michigan suggest that the recent increase in use of certain drug measures is "across the board" and not restricted to particular groups or geographic areas. These findings are taken from graphs, and their statistical significance is not known to NIDA. Some of the patterns are as follows:

- o The seniors' increase in past year use of **marijuana/hashish** from 1992 to 1993 was found in the northeastern, north central, and southern states; students in the western states did not show the same increase.
- o From 1992 to 1993, the increase in seniors' past year use of **marijuana/hashish** occurred at schools in large metropolitan areas, other metropolitan areas, and outside metropolitan areas.
- o Data on past year **marijuana/hashish** use according to race/ethnicity showed increases from 1992 to 1993 for black and white seniors but no comparable increase for Hispanic seniors.
- o The 1992-to-1993 increase in seniors' past year **marijuana/hashish** use was observed in each social class.
- o Seniors' past year use of **inhalants**, which did not change significantly from 1992 to 1993 overall, appeared to increase in the northeastern and southern states and to decline in the north central states.
- o The increase in senior's past year **LSD** use from 1992 to 1993 appeared to occur in each of the four regions of the country, in all areas regardless of urbanicity, and in each social class. The increase appeared to occur for white and black students but not for Hispanic students.

SUMMARY

Mr. Chairman, as you can see, the findings of the 1993 Monitoring The Future Study show reason for concern. Rates of drug use are up in a number of categories, and the changes have been observed among eighth and tenth graders as well as among seniors. Taken together with reductions in perceived risk and disapproval of drug use, the news is not good.

Thank you, Mr. Chairman and members of the Subcommittee. I would be pleased to answer any questions you may have.

TABLE 1
Trends in Prevalence¹ of Various Drugs for Three Populations:
Eighth, Tenth, and Twelfth Graders

	Lifetime			Annual			30-Day			Daily		
	1991	1992	1993	'92-'93 change	1991	1992	1993	'92-'93 change	1991	1992	1993	'92-'93 change
Any Illicit Drug ^a												
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	44.1	40.7	42.9	+2.2s	29.4	27.1	31.0	+3.9ss	16.4	14.4	18.3	+3.9ss
Any Illicit Drug ^b												
Other Than Marijuana	—	—	—	—	—	—	—	—	—	—	—	—
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	28.9	25.1	26.7	+1.6	16.2	14.9	17.1	+2.2s	7.1	6.3	7.9	+1.6ss
Marijuana/Hashish												
8th Grade	10.2	11.2	12.6	+1.4ss	6.2	7.2	9.2	+2.0ss	3.2	3.7	5.1	+1.4ss
10th Grade	14.4	13.1	14.7	+1.6ss	8.7	10.2	11.7	+3.0ss	4.7	5.1	6.5	+1.4ss
12th Grade	30.7	32.6	35.3	+2.7s	23.9	21.9	26.0	+4.1ss	13.8	11.9	15.3	+3.4ss
Inhalants ^{c,4}												
8th Grade	17.6	17.4	19.4	+2.0s	9.0	9.5	11.0	+1.5s	4.4	4.7	5.4	+0.7
10th Grade	15.7	16.6	17.5	+0.9	7.1	7.5	8.0	+0.4	2.7	2.7	3.3	+0.6s
12th Grade	17.6	16.6	17.4	+0.8	6.6	6.2	7.0	+0.8	2.4	2.3	2.5	+0.2
Hallucinogens ^d												
8th Grade	3.2	3.8	3.9	+0.1	1.9	2.5	2.6	+0.1	0.8	1.1	1.2	+0.1
10th Grade	6.1	6.4	6.8	+0.4	4.0	4.3	4.7	+0.4	1.6	1.8	1.9	+0.1
12th Grade	9.6	9.2	10.9	+1.7ss	5.8	5.9	7.4	+1.5ss	2.2	2.1	2.7	+0.6s
LSD												
8th Grade	2.7	3.2	3.5	+0.3	1.7	2.1	2.3	+0.2	0.6	0.9	1.0	+0.1
10th Grade	5.6	5.8	6.2	+0.4	3.7	4.0	4.2	+0.2	1.5	1.6	1.6	0.0
12th Grade	5.8	5.6	10.3	+1.7ss	3.2	5.6	6.8	+1.2ss	1.9	2.0	2.4	+0.4
PCP ^e												
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	2.9	2.4	2.9	+0.5	1.4	1.4	1.4	0.0	0.5	0.6	1.0	+0.4
Hallucinogens ^f												
Other Than LSD	14	17	17	0.0	0.7	1.1	1.0	-0.1	0.3	0.4	0.5	+0.1
8th Grade	22	25	28	+0.3	13	14	19	+5.5s	0.4	0.5	0.7	+0.2
10th Grade	3.7	3.3	3.9	+0.6	2.0	1.7	2.2	+0.5s	0.7	0.5	0.8	+0.3s
12th Grade												

SOURCE: Monitoring The Future Study, The University Of Michigan

(Table continued on next page)

TABLE 1 (continued)

Trends in Prevalence of Various Drugs for Three Populations:
Eighth, Tenth, and Twelfth Graders

	Lifetime			Annual			30-Day			Daily		
	92-93 change			92-93 change			92-93 change			92-93 change		
	1991	1992	1993	1991	1992	1993	1991	1992	1993	1991	1992	1993
Cocaine												
8th Grade	23	29	29	0.0	1.1	1.5	17	+0.2	0.5	0.7	0.7	0.0
10th Grade	41	33	3.6	+0.3	2.2	1.9	2.1	+0.2	0.7	0.7	0.3	+0.2
12th Grade	7.8	6.1	6.1	0.0	3.5	3.1	3.3	+0.2	1.4	1.3	1.3	+0.0
Crack												
8th Grade	13	16	17	+0.1	0.7	0.9	1.0	+0.1	0.3	0.5	0.4	-0.1
10th Grade	17	1.5	1.8	+0.3	0.9	0.9	1.1	+0.2	0.3	0.4	0.5	+0.1
12th Grade	3.1	2.6	2.6	0.0	1.5	1.5	1.5	0.0	0.7	0.6	0.7	+0.1
Other Cocaine ^d												
8th Grade	20	24	24	0.0	1.0	1.2	1.3	+0.1	0.5	0.5	0.6	+0.1
10th Grade	28	5.9	5.3	+0.3	2.1	3.7	1.8	+0.1	0.6	0.6	0.7	+0.1
12th Grade	7.9	5.9	5.4	+0.1	3.2	2.6	2.9	+0.3	1.2	1.0	1.2	+0.2
Heroin												
8th Grade	12	12	12	0.0	0.7	0.7	0.7	0.0	0.3	0.4	0.4	0.0
10th Grade	12	12	12	+0.1	0.4	0.6	0.5	-0.1	0.2	0.3	0.2	-0.1
12th Grade	0.9	1.2	1.1	-0.1	0.4	0.6	0.5	-0.1	0.2	0.3	0.2	-0.1
Ice ^e												
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	3.3	2.9	3.1	+0.2	1.4	1.3	1.7	+0.4	0.6	0.5	0.6	+0.1
12th Grade	—	—	—	—	—	—	—	—	—	—	—	—
Other Opiates												
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	6.6	6.1	6.4	+0.3	3.5	3.3	3.6	+0.3	1.1	1.2	1.3	+0.1
12th Grade	—	—	—	—	—	—	—	—	—	—	—	—
Stimulants												
8th Grade	10.5	10.8	11.8	+1.0	6.2	6.5	7.2	+0.7	2.6	3.3	3.6	+0.3
10th Grade	13.2	13.1	14.9	+1.8 _{ss}	8.2	8.5	9.2	+0.7	2.6	3.3	3.6	+0.3
12th Grade	15.4	13.9	15.1	+1.2	8.2	7.1	8.4	+1.3 _{ss}	3.2	2.8	3.7	+0.9 _{ss}
Tranquilizers												
8th Grade	3.8	4.1	4.4	+0.3	1.8	2.0	2.1	+0.1	0.8	0.8	0.9	+0.1
10th Grade	5.8	5.9	5.7	-0.2	3.2	3.5	3.3	-0.2	1.2	1.5	1.1	-0.4 _s
12th Grade	7.2	6.0	6.4	+0.4	3.6	2.8	3.5	+0.7 _{ss}	1.4	1.0	1.2	+0.2
Nitrites												
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	1.6	1.5	1.4	-0.1	0.9	0.5	0.9	+0.4	0.4	0.3	0.6	+0.3
Barbiturates												
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	6.2	5.5	6.3	+0.8	3.4	2.8	3.4	+0.6	1.4	1.1	1.3	+0.2

TABLE 1 (continued)
Trends in Prevalence of Various Drugs for Three Populations:
Eighth, Tenth, and Twelfth Graders

	Lifetime			Annual			30-Day			Daily		
	1991	1992	1993	1991	1992	1993	1991	1992	1993	1991	1992	1993
Alcohol^a												
Any use	70.1	69.3	67.1	-2.2	54.0	53.7	51.6	-2.1	25.1	26.1	26.2	+0.1
8th Grade	83.8	82.3	80.8	-1.5	72.3	70.2	69.3	-0.9	42.8	39.9	41.5	+1.6
10th Grade	88.0	87.5	87.0	-0.5	77.7	76.8	76.0	-0.8	54.0	51.3	51.0	-0.3
12th Grade										0.5	0.6	+0.2
										1.3	1.2	-0.1
										3.6	3.4	-0.2
											2.5	-0.9
Been Drunk^b												
Any use	26.7	26.8	26.4	-0.4	17.5	18.3	18.2	-0.1	7.6	7.5	7.8	+0.3
8th Grade	50.0	47.7	47.9	+0.2	40.1	37.0	37.8	+0.8	20.5	18.1	19.8	+1.7
10th Grade	65.4	63.4	62.5	-0.9	52.7	50.3	49.6	-0.7	31.6	29.9	28.9	-1.0
12th Grade										0.1	0.1	0.2
										0.2	0.3	+0.1
										0.9	0.8	+0.1
5+ drinks in last 2 weeks												
Any use	—	—	—	—	—	—	—	—	—	—	—	—
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	—	—	—	—	—	—	—	—	—	—	—	—
										12.9	13.4	+0.5
										25.8	27.9	+2.1
										25.8	27.9	+2.1
Cigarettes												
Any use	44.0	45.2	45.3	+0.1	—	—	—	—	—	—	—	—
8th Grade	55.1	53.5	56.3	+2.8	—	—	—	—	—	—	—	—
10th Grade	63.1	61.8	61.9	+0.1	—	—	—	—	—	—	—	—
12th Grade										7.2	7.0	-0.2
										12.6	12.3	-0.3
										18.5	17.2	-1.3
											14.2	+1.8
											19.0	+1.8
1/2 pack/day												
Any use	—	—	—	—	—	—	—	—	—	—	—	—
8th Grade	—	—	—	—	—	—	—	—	—	—	—	—
10th Grade	—	—	—	—	—	—	—	—	—	—	—	—
12th Grade	—	—	—	—	—	—	—	—	—	—	—	—
										3.1	2.9	-0.2
										6.5	6.0	-0.5
										10.7	10.0	-0.7
											10.9	+0.9
Smokeless Tobacco^c												
Any use	22.2	20.7	18.7	-2.0	—	—	—	—	—	—	—	—
8th Grade	28.2	26.6	28.1	+1.5	—	—	—	—	—	—	—	—
10th Grade	—	32.4	31.0	-1.4	—	—	—	—	—	—	—	—
12th Grade										1.8	1.8	0.0
										3.3	3.3	0.0
										—	4.3	+1.0
											3.3	-1.0
Steroids^d												
Any use	1.9	1.7	1.6	-0.1	1.0	1.1	0.9	-0.2	0.4	0.5	0.5	0.0
8th Grade	1.8	1.7	1.7	0.0	1.1	1.1	1.0	-0.1	0.6	0.6	0.5	-0.1
10th Grade	2.1	2.1	2.0	-0.1	1.4	1.1	1.2	+0.1	0.8	0.6	0.7	+0.1
12th Grade										0.1	0.1	0.0
										*	*	0.0
										0.1	0.1	0.0
										0.1	0.1	0.0

NOTES: Level of significance of difference between the two years: s = .05, ss = .01, sss = .001. * indicates data not available. ** indicates less than .05 percent. Any apparent inconsistency between the change estimate and the prevalence estimates for the two years is due to rounding error. ^aAny use of alcohol means the percent of a population using the drug one or more times in the specified time interval (i.e., in lifetime, past 12 months, or past 30 days). Daily use is defined as using 26 or more times in the past 30 days. (For cigarettes and smokeless tobacco, daily use is the use once or more per day in the past 30 days.)

^bApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^cApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^dApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^eApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^fApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^gApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^hApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ⁱApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^jApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^kApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^lApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^mApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ⁿApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^oApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^pApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^qApprox. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^rApprox. 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N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{aw}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ax}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ay}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{az}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ba}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bb}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bc}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bd}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{be}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bf}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bg}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bh}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bi}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bj}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bk}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bl}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bm}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bn}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bo}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bp}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bq}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{br}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bs}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bt}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bu}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bv}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bw}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bx}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{by}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{bz}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ca}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cb}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cc}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cd}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ce}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cf}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cg}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ch}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ci}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cj}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ck}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cl}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cm}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cn}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{co}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cp}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cq}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cr}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cs}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ct}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cu}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cv}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cw}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cx}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cy}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{cz}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{da}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{db}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{dc}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{dd}Approx. 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N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{dt}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{du}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{dv}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{dw}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{dx}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{dy}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{dz}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ea}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{eb}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ec}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ed}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in 1993. ^{ee}Approx. N = 14,800 in 1991; 14,800 in 1992; 14,800 in

TABLE 2
Long-Term Trends in Lifetime Prevalence of Various Types of Drugs for Twelfth Graders

[illegible]

NOTES: Level of significance of difference between the two most recent classes: $\alpha = 0.05$, $\alpha = 0.01$, $\alpha = 0.001$. * indicates data not available

SOURCE. Monitoring The Future Study, The University Of Michigan

Footnotes for Table 2-Table 5

- * Use of "any illicit drugs" includes any use of marijuana, hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, barbiturates, methaqualone (excluded since 1990), or tranquilizers not under a doctor's orders.
- ^b Beginning in 1982 the question about stimulant use (i.e. amphetamines) was revised to exclude the inappropriate reporting of non-prescription stimulants. The prevalence rate dropped slightly as a result of this methodological change.
- ^c Use of "other illicit drugs" includes any use of hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, barbiturates, methaqualone (excluded since 1990), or tranquilizers not under a doctor's orders.
- ^d Data based on four questionnaire forms in 1976-1988; N is four-fifths of N indicated. Data based on five questionnaire forms in 1989-1993; N is five-sixths of N indicated.
- ^e Adjusted for underreporting of amyl and butyl nitrites.
- ^f Data based on a single questionnaire form; N is one-fifth of N indicated in 1979-1988 and one-sixth of N indicated in 1989-1993.
- ^g Question text changed slightly in 1987.
- ^h Adjusted for underreporting of PCP.
- ⁱ Data based on a single questionnaire form in 1986; N is one-fifth of N indicated. Data based on two questionnaire forms in 1987-1989; N is two-fifths of N indicated in 1987-1988 and two-sixths of N indicated in 1989. Data based on six questionnaire forms in 1990-1993.
- ^j Data based on a single questionnaire form in 1987-1989; N is one-fifth of N indicated in 1987-1988 and one-sixth of N indicated in 1989. Data based on four questionnaire forms in 1990-1993; N is four-sixths of N indicated.
- ^k Only drug use which was not under a doctor's orders is included here.
- ^l Data based on two questionnaire forms; N is two-sixths of N indicated. Steroid data based on a single questionnaire form in 1989-1990.
- ^m Data based on five questionnaire forms in 1975-1988, six questionnaire forms in 1989, and one questionnaire form in 1990-1993. N is one-sixth of N indicated in 1990-1993. Smokeless tobacco was always included in only one questionnaire form.
- ⁿ Data based on three of the six questionnaire forms in 1993. N is one-half N indicated.

SOURCE. Monitoring The Future Study, The University Of Michigan

TABLE 3
Long-Term Trends in Annual Prevalence of Various Types of Drugs for Twelfth Graders

	Percent who used in last twelve months																92-93 change	
	Class 1975	Class 1976	Class 1977	Class 1978	Class 1979	Class 1980	Class 1981	Class 1982	Class 1983	Class 1985	Class 1986	Class 1987	Class 1988	Class 1989	Class 1990	Class 1991		Class 1992
Approx N =	9400	15400	17100	17800	15500	15900	17500	17700	16300	15900	16000	15200	16300	16700	15200	15000	15800	16300
Any Illicit Drug ^{a,b}	45.0	48.1	51.1	53.8	54.2	53.1	52.1	49.4	47.4	45.8	46.3	44.3	41.7	38.5	35.4	29.4	27.1	+3.9ass
Any Illicit Drug Other Than Marijuana ^{a,b}	26.2	25.4	26.0	27.1	28.2	30.4	34.0	30.1	28.4	28.0	27.4	25.9	24.1	21.1	20.0	17.9	16.2	+2.2ss
Marijuana/Hashish	40.0	44.5	47.6	50.2	50.8	48.8	46.1	44.3	42.3	40.0	40.6	38.8	36.3	33.1	29.6	27.0	23.9	+1.1ss
Inhalants ^d	—	3.0	3.7	4.1	5.4	4.6	4.1	4.5	4.3	5.1	5.7	6.1	6.9	6.5	5.9	6.6	6.2	+0.8
Inhalants Adjusted ^d	—	—	—	8.9	7.9	6.1	6.6	6.2	7.2	7.5	8.9	8.1	7.1	6.9	7.5	6.9	6.4	+1.0
Any/Butyl Nitrites ^{e,f}	—	—	—	—	6.5	5.7	3.7	3.6	3.0	4.0	4.0	4.7	2.6	1.7	1.4	0.9	0.5	+0.9
Hallucinogens	11.2	9.4	8.8	9.6	9.9	9.3	9.0	8.1	7.3	6.5	6.3	6.0	6.4	5.5	5.6	5.9	7.4	+1.5ss
Hallucinogens Adjusted ^d	—	—	—	11.8	10.4	10.1	9.0	8.3	7.3	7.6	7.6	6.7	5.8	6.2	6.0	6.1	6.2	+1.2ss
LSD	7.2	6.4	5.5	6.3	6.6	6.5	6.5	6.1	5.4	4.7	4.4	4.5	5.2	4.8	4.9	5.4	5.2	+1.2ss
PCP ^g	—	—	—	—	7.0	4.4	3.2	2.2	2.6	2.3	2.9	2.4	1.3	1.2	2.4	1.2	1.4	0.0
Cocaine	5.6	6.0	7.2	9.0	12.0	12.3	12.4	11.5	11.4	11.6	13.1	12.7	10.3	7.9	6.5	5.3	3.5	+0.2
Crack ^h	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	+0.3
Other cocaine ⁱ	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	+0.3
Heroin	1.0	0.8	0.8	0.8	0.5	0.5	0.6	0.6	0.5	0.6	0.5	0.6	0.5	0.4	0.6	0.5	0.4	-0.1
Other opiates ^j	5.7	5.7	6.4	6.0	6.2	6.3	5.9	5.3	5.1	5.2	5.9	5.2	5.3	4.6	4.4	4.5	3.5	+0.3
Stimulants ^k	16.2	15.8	16.3	17.1	18.3	20.8	26.0	20.3	17.9	17.7	15.8	13.4	12.2	10.9	10.8	9.1	8.2	+1.3ss
Crystal Meth. (Ice) ^l	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1.3	1.4	+0.4
Sedatives ^{m,n}	11.7	10.7	10.8	9.9	9.9	10.3	10.5	9.1	7.9	6.6	5.8	5.2	4.1	3.7	3.7	3.6	3.6	+0.5
Barbiturates ^l	10.7	9.6	9.3	8.1	7.5	6.8	6.6	5.5	5.2	4.9	4.6	4.2	3.6	3.2	3.3	3.4	2.8	+0.6
Methaqualone ^{m,n}	5.1	4.7	5.2	4.9	5.9	7.2	7.6	6.8	5.4	3.8	2.8	2.1	1.5	1.3	0.7	0.5	0.6	-0.2
Tranquilizers ^o	10.6	10.3	10.8	9.9	9.6	8.7	8.0	7.0	6.9	6.1	6.1	5.8	5.5	4.8	3.8	3.5	3.6	+0.7s
Alcohol ^p	84.8	85.7	87.0	87.7	88.1	87.9	87.0	86.8	87.3	86.0	85.6	84.5	85.7	85.3	82.7	80.6	77.7	-0.8
Beer Drunk ^q	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	52.7	-0.7
Cigarettes	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Smokeless Tobacco ^r	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Steroids ^l	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1.9	1.7	1.4	+0.1

NOTES: Level of significance of difference between the two most recent classes: $s = 0.5$, $ss = 0.1$, $sss = 0.01$. "—" indicates data not available.

See Table 2 for relevant footnotes

SOU — Monitoring The Future Study, The University Of Michigan

TABLE 4
Long-Term Trends in Thirty-Day Prevalence of Various Types of Drugs for Twelfth Graders

		Percent who used in last thirty days																		
		Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	Class of 1990	Class of 1991	Class of 1992	Class of 1993
		Approx. N =																		
		9400	15400	17100	17800	15500	15900	17500	17700	16300	15900	16000	15200	16300	16500	16700	15200	15000	15800	16300
Any Illicit Drug ^a		30.7	34.2	37.6	38.9	38.9	37.2	36.9	32.5	30.5	29.2	29.7	27.1	24.7	21.3	19.7	17.2	16.4	14.4	18.3
Any Illicit Drug Other Than Marijuana ^{a,c}		15.4	13.9	15.2	15.1	16.8	18.4	21.7	17.0	15.4	15.1	14.9	13.2	11.6	10.0	9.1	8.0	7.1	6.3	7.9
Marijuana/Hashish		27.1	32.2	35.4	37.1	36.5	33.7	31.6	28.5	27.0	25.2	25.7	23.4	21.0	18.0	16.7	14.0	13.8	11.9	15.5
Inhalants ^d		—	0.9	1.3	1.5	1.7	1.4	1.5	1.5	1.7	1.9	2.2	2.5	2.8	2.6	2.3	2.7	2.4	2.3	2.5
Inhalants Adjusted ^d		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Amyl/Butyl Nitrites ^{d,e}		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Hallucinogens		4.7	3.4	4.1	3.9	4.0	3.7	3.7	3.4	2.8	2.6	2.5	2.5	2.2	2.2	2.2	2.2	2.1	2.7	+0.6s
Hallucinogens Adjusted ^d		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
LSD		2.3	1.9	2.1	2.1	2.4	2.3	2.5	2.4	1.9	1.5	1.6	1.7	1.8	1.8	1.8	1.9	1.9	2.0	+1.0s
PCP ^d		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	+0.4
Cocaine		1.9	2.0	2.9	3.9	5.7	5.2	5.8	5.0	4.9	5.8	6.7	6.2	4.3	3.4	2.8	1.9	1.4	1.3	0.0
Crack ^d		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	+0.1
Other cocaine ^d		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	+0.1
Heroin		0.4	0.2	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.2	0.2	0.2	0.3	0.2	0.2	0.3	-0.1
Other opiates ^d		2.1	2.0	2.8	2.1	2.4	2.1	1.8	1.8	1.8	1.8	1.8	1.6	1.6	1.6	1.5	1.1	1.2	1.3	+0.1
Stimulants ^d		8.5	7.7	8.8	8.7	9.9	12.1	15.8	10.7	8.9	8.3	6.8	5.5	5.2	4.6	4.2	3.7	3.2	2.8	+0.9s
Crystal Meth. (1cc) ³		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	+0.1
Sedatives ^{d,m}		5.4	4.5	5.1	4.2	4.4	4.8	4.6	3.4	3.0	2.3	2.4	2.2	1.7	1.4	1.6	1.4	1.5	1.2	1.3
Barbiturates ^d		4.7	3.9	4.3	3.2	3.2	2.9	2.6	2.0	2.1	1.7	2.0	1.8	1.4	1.2	1.4	1.3	1.4	1.1	1.3
Methaqualone ^d		2.1	1.6	2.3	1.9	2.3	3.3	3.1	2.4	1.1	1.0	0.8	0.6	0.5	0.6	0.2	0.2	0.4	0.1	-0.3
Tranquilizers ^d		4.1	4.0	4.6	3.4	3.7	3.1	2.7	2.4	2.5	2.1	2.1	2.1	2.0	1.5	1.3	1.2	1.4	1.0	1.2
Alcohol ^d		68.2	68.3	71.2	72.1	71.8	72.0	70.7	69.7	69.4	67.2	65.9	65.3	66.4	63.9	60.0	57.1	54.0	51.3	51.0
Beer/Drunk ¹		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	-1.0
Cigarettes		36.7	38.8	38.4	36.7	34.1	30.5	29.4	30.0	30.3	29.3	30.1	29.6	29.4	28.7	28.6	29.4	28.3	27.8	29.9
Smokeless Tobacco ^m		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	+2.1s
Steroids ^d		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	-0.7
		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	+0.1

NOTES: Level of significance of difference between the two most recent classes. $s = .05$, $ss = .01$, $sss = .001$. "—" indicates data not available.

See Table 2 for relevant footnotes.

TABLE 5
Long-Term Trends in Thirty-Day Prevalence of Daily Use of Various Types of Drugs for Twelfth Graders

Percent who used daily in last thirty days																					
Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	Class of 1990	Class of 1991	Class of 1992	Class of 1993	'92-'93 change		
Approx N =																					
9400	15400	17100	17800	15500	15900	17500	17700	16300	15000	16000	15200	16300	16300	16700	15200	15000	15800	16300			
Marijuana/Hashish	6.0	8.2	9.1	10.7	10.3	9.1	7.0	6.3	5.5	5.0	4.9	1.0	3.3	2.7	2.9	2.2	2.0	1.9	2.4	+0.5s	
Inhalants ^a	—	*	*	0.1	*	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	0.2	0.2	0.3	0.2	0.1	0.0		
Inhalants Adjusted ^a	—	—	—	0.1	0.2	0.2	0.2	0.2	0.2	0.4	0.4	0.4	0.3	0.3	0.3	0.5	0.2	0.1	0.0		
Amyl & Butyl Nitrites ^a	—	—	—	*	0.1	0.1	0.0	0.2	0.1	0.3	0.5	0.3	0.1	0.3	0.1	0.2	0.1	0.1	0.0		
Hallucinogens	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	*	0.1	0.1	0.1	0.1	0.1	0.0		
Hallucinogens Adjusted ^a	—	—	—	0.2	0.2	0.1	0.2	0.2	0.2	0.3	0.3	0.2	*	0.3	0.3	0.1	0.1	0.1	0.0	-0.1	
LSD ^a	*	*	*	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	*	*	0.1	0.1	0.1	0.1	0.0		
PCP ^a	—	—	—	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.2	0.3	0.1	0.2	0.1	0.1	0.1	0.1	+0.1		
Cocaine	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.4	0.4	0.3	0.2	0.3	0.2	0.1	0.1	0.1	0.0		
Crack ^a	—	—	—	—	—	—	—	—	—	—	—	—	—	0.1	0.2	0.1	0.1	0.1	0.0		
Other cocaine ^a	—	—	—	—	—	—	—	—	—	—	—	—	—	0.2	0.2	0.1	0.1	0.1	0.0		
Heroin	0.1	*	*	*	*	*	*	0.1	*	*	*	*	*	0.1	*	*	*	*	0.0		
Other opiates ^a	0.1	0.1	0.2	0.1	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	*	*	0.0		
Stimulants ^a	0.5	0.4	0.5	0.5	0.6	0.7	1.2	0.7	0.8	0.6	0.4	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.0		
Crystal Meth. (Ice) ^f	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0.1	0.1	0.1	-0.1	
Sedatives ^a	0.3	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0		
Barbiturates ^a	0.1	0.1	0.2	0.1	*	0.1	0.1	0.1	0.1	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0		
Methaqualone ^a	*	*	*	*	*	0.1	0.1	0.1	*	*	*	*	*	0.1	*	0.1	*	0.1	0.1	-0.1	
Tranquilizers ^a	0.1	0.2	0.3	0.1	0.1	0.1	0.1	0.1	0.1	*	*	0.1	*	0.1	0.1	0.1	*	*	0.0		
Alcohol	5.7	5.6	6.1	5.7	6.9	6.0	6.0	5.7	5.5	4.8	5.0	4.8	4.8	4.2	4.2	3.7	3.6	3.4	2.5	-0.9s	
Daily ^b	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0.9	0.8	+0.1	
Been drunk daily ^f	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—		
5+ drinks in a row/ last 2 weeks	36.8	37.1	39.4	40.3	41.2	41.2	41.4	40.5	40.8	38.7	36.7	36.8	37.5	34.7	33.0	32.2	29.8	27.9	27.5	-0.4	
Cigarettes	26.9	28.8	28.8	27.5	25.4	21.3	20.3	21.1	21.2	18.7	19.5	18.7	18.7	18.1	18.9	19.1	18.5	17.2	19.0	+1.8ss	
Daily	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—		
Half-pack or more per day	17.9	19.2	19.4	18.8	16.5	14.3	13.5	14.2	13.8	12.3	12.5	11.4	11.4	10.6	11.2	11.3	10.7	10.0	10.9	+0.9	
Smokeless Tobacco ^a	—	—	—	—	—	—	—	—	—	—	—	—	—	4.7	5.1	4.3	3.3	—	—	-1.0ss	
Steroids ^g	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0.1	0.2	0.1	0.1	0.1	+0.1	

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. "—" indicates data not available. Any apparent inconsistency between the change estimate and the prevalence estimates for the two most recent classes is due to rounding error. * indicates less than .05 per cent.

See Table 2 for relevant footnotes.

TABLE 6

**Trends in Harmfulness of Drugs as Perceived
by Eighth, Tenth, and Twelfth Graders, 1991-1993**

Q	How much do you think people risk harming themselves physically or in other ways, if they . . .	Percentage saying "great risk"									
		8th Grade			10th Grade			12th Grade			'92-93 change
		1991	1992	1993	1991	1992	1993	1991	1992	1993	
Q	Try marijuana once or twice	40.4	39.1	36.2	30.0	31.0	29.7	27.1	24.5	21.9	-2.6
	Smoke marijuana occasionally	55.0	55.0	55.0	48.6	48.9	46.1	40.6	39.6	35.6	-4.0s
	Smoke marijuana regularly	83.8	82.0	79.6	82.1	81.1	78.5	78.6	76.5	72.5	-4.0ss
	Try inhalants once or twice	35.9	37.0	36.5	37.8	38.7	40.9	—	—	—	—
	Take inhalants regularly	65.8	64.4	64.6	69.8	67.9	69.6	—	—	—	—
	Try crack once or twice	69.8	61.2	57.9	70.4	69.6	66.6	60.6	62.4	57.6	-4.8ss
	Take crack occasionally	82.2	79.6	76.8	87.4	86.4	84.4	76.5	76.3	73.9	-2.4
	Try cocaine powder once or twice	55.5	54.1	50.7	59.1	59.2	57.5	53.6	57.1	53.2	-3.9s
	Take cocaine powder occasionally	77.0	74.3	71.8	82.2	80.1	79.1	69.8	70.8	68.6	-2.2
	Try one or two drinks of an alcoholic beverage (beer, wine, liquor)	11.0	12.1	12.4	9.0	10.1	10.9	9.1	8.6	8.2	-0.4
Q	Take one or two drinks nearly every day	31.8	32.4	32.6	36.1	36.8	35.9	32.7	30.6	28.2	-2.4
	Have five or more drinks once or twice each weekend	59.1	58.0	57.7	54.7	55.9	54.9	48.6	49.0	48.3	-0.7
	Smoke one or more packs of cigarettes per day	51.6	50.8	52.7	60.3	59.3	60.7	69.4	69.2	69.5	+0.3
	Use smokeless tobacco regularly	35.1	35.1	36.9	40.3	39.6	44.2	37.4	35.5	38.9	+3.4s
	Take steroids*	64.2	69.5	70.2	67.1	72.7	73.4	65.6	70.7	69.1	-1.6
	Approx N =	17437	18662	18366	14719	14808	15298	2549	2684	2759	

NOTE: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001.
— indicates data not available.

SOURCE: Monitoring The Future Study, The University Of Michigan

*Answer alternatives were: (1) No risk, (2) Slight risk, (3) Moderate risk, (4) Great risk, (5) Can't say, drug unfamiliar.
*8th and 10th grade: Data based on a single questionnaire form in 1993; N is one-half N indicated.

TABLE 7
Long-Term Trends in Harmfulness of Drugs as Perceived by Twelfth Graders

Q	How much do you think people risk having their beliefs (positively or in other ways), if they ...	Percentage saying "Great risk"																						
		Class 1975	Class 1976	Class 1977	Class 1978	Class 1979	Class 1980	Class 1981	Class 1982	Class 1983	Class 1984	Class 1985	Class 1986	Class 1987	Class 1988	Class 1989	Class 1990	Class 1991	Class 1992	Class 1993	Class 1994			
	Try marijuana once or twice	15.1	11.4	9.5	8.1	9.4	10.0	13.0	11.5	12.7	14.7	14.6	15.1	18.4	19.0	23.6	23.1	27.1	24.5	21.9	-2.6			
	Smoke marijuana occasionally	18.1	15.0	13.4	12.5	14.7	19.1	18.3	20.6	22.6	24.5	25.0	30.4	31.7	36.5	36.9	40.6	39.6	35.6	-4.0s				
	Smoke marijuana regularly	43.3	38.6	36.4	34.9	42.0	50.4	57.6	60.4	62.8	69.6	74.4	71.3	73.5	77.0	77.8	78.6	76.5	72.5	-4.0s				
	Try LSD once or twice	49.4	45.7	43.2	42.7	44.9	43.5	44.9	44.7	45.4	43.5	42.0	44.9	45.7	44.0	44.7	46.6	42.3	39.5	-2.8				
	Take LSD regular	81.4	80.8	79.1	81.1	82.4	83.0	83.5	83.5	83.2	85.8	82.9	82.6	83.8	84.2	84.3	84.5	84.3	81.8	-2.4				
	Try PCP once or twice	—	—	—	—	—	—	—	—	—	—	—	—	—	55.6	56.8	56.6	55.2	51.7	54.8	50.8	-4.0s		
	Try cocaine once or twice	42.6	39.1	35.6	33.2	31.5	31.3	32.1	32.8	33.0	35.7	34.0	33.5	47.9	51.2	54.9	59.4	59.4	56.8	57.6	40.8			
	Take cocaine occasionally	—	—	—	—	—	—	—	—	—	—	—	—	—	54.2	66.8	69.2	71.8	73.9	75.5	76.1	73.3		
	Take cocaine regularly	73.1	72.3	68.2	68.2	69.5	69.2	71.2	73.0	74.3	78.8	79.0	82.2	88.5	89.2	90.2	91.1	90.4	90.2	90.1	-0.1			
	Try crack once or twice	—	—	—	—	—	—	—	—	—	—	—	—	—	57.0	69.1	62.9	64.3	60.6	69.4	67.6	-4.8s		
	Take crack occasionally	—	—	—	—	—	—	—	—	—	—	—	—	—	70.4	73.2	75.3	80.4	76.5	76.3	73.9	-7.1s		
	Take crack regularly	—	—	—	—	—	—	—	—	—	—	—	—	—	84.6	84.8	85.6	91.6	90.1	89.3	87.5	-1.8		
	Try cocaine powder once or twice	—	—	—	—	—	—	—	—	—	—	—	—	—	45.3	51.7	53.8	53.9	53.6	57.1	53.2	-3.9s		
	Take cocaine powder regularly	—	—	—	—	—	—	—	—	—	—	—	—	—	56.8	61.9	65.8	71.1	69.8	70.8	68.2	-2.2		
	Try heroin once or twice	60.1	58.9	55.8	53.9	53.4	53.1	52.9	51.1	50.8	48.8	47.3	45.8	53.6	54.0	53.8	55.4	55.2	50.9	50.7	-0.2			
	Take heroin occasionally	75.6	75.6	71.9	71.4	70.9	70.9	72.2	69.8	71.8	70.7	69.4	72.7	73.8	74.5	73.8	75.2	74.9	73.2	72.2	-0.2			
	Take heroin regularly	97.2	88.6	86.1	86.6	87.5	86.2	87.5	86.0	86.1	87.2	86.0	87.1	88.7	88.8	89.5	90.2	89.8	89.2	88.3	-0.9			
	Try amphetamines once or twice	35.4	33.4	30.8	29.9	29.7	29.7	28.4	25.3	24.7	25.4	25.2	25.1	29.1	28.6	32.8	32.2	36.3	32.6	31.3	-1.3			
	Take amphetamines regularly	69.0	67.3	66.6	67.1	69.9	69.1	68.1	64.8	64.7	67.2	67.3	69.8	71.1	72.1	72.4	72.4	72.4	69.9	62.5	-2.5			
	Try crystal meth. (ice) once or twice	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—			
	Try bath salts once or twice	34.8	32.5	31.2	31.3	30.7	30.9	28.4	27.5	27.0	27.4	26.1	25.4	30.9	29.7	32.2	32.4	35.1	32.2	29.2	-3.0			
	Take bath salts regularly	69.1	67.7	66.6	68.4	71.6	72.2	69.9	67.6	67.7	69.5	68.3	67.2	69.4	69.6	70.5	70.2	70.5	70.2	66.1	-1.4s			
	Try one or two drinks of an alcoholic beverage /beer.	5.3	4.8	4.1	3.4	4.1	3.8	4.6	3.5	4.2	4.6	5.0	4.6	6.2	6.0	6.0	8.3	9.1	8.6	8.2	-0.4			
	Take one or two drinks nearly every day	21.5	21.2	18.5	19.6	22.6	20.3	21.6	21.6	21.6	23.0	24.4	25.1	26.2	27.3	28.5	31.3	32.7	30.6	28.2	-2.4			
	Take four or five drinks nearly every day	63.5	61.0	62.9	63.1	66.2	65.7	64.5	65.5	66.8	68.4	69.8	66.5	69.7	68.5	69.8	70.9	69.5	70.5	67.8	-2.7			
	Have five or more drinks once or twice each weekend	37.8	37.0	34.7	34.5	34.9	35.9	36.3	36.0	38.6	41.7	43.0	39.1	41.9	42.6	44.0	47.1	48.6	49.0	44.0	-0.7			
	Smoke one or more packs of cigarettes per day	51.3	56.4	58.4	59.0	63.0	63.7	63.3	60.5	61.2	63.8	66.5	66.0	68.6	68.0	67.2	68.2	69.4	69.2	69.5	+0.3			
	Use smokeless tobacco regularly	—	—	—	—	—	—	—	—	—	—	—	—	25.8	30.0	33.2	32.9	34.2	37.4	35.5	38.9	+3.4s		
	Take steroids	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	63.8	69.9	65.6	70.7	69.1	-1.6
		2804	2918	3052	3770	3250	3234	3804	3557	3305	3262	3250	3020	3315	3276	2796	2553	2549	2684	2759				
		Approx. N =																						

NOTE: Level of significance of difference between the two most recent classes: $s = .05$, $ss = .01$, $sss = .001$. '-' indicates data not available.

SOUR Monitoring The Future Study, The University Of Michigan.

*Answer alternatives were: (1) No risk, (2) Slight risk, (3) Moderate risk, (4) Great risk, and (5) Can't say, drug unfamiliar.

TABLE 8
Trends in Disapproval of Drug Use
by Eighth, Tenth, and Twelfth Graders, 1991-1993

Q	Do you disapprove of people who . . .	Percent who disapprove or strongly disapprove ^a											
		8th Grade			10th Grade			12th Grade ^b			92-93 change		
		1991	1992	1993	1991	1992	1993	1991	1992	1993			
	Try marijuana once or twice	84.6	82.1	79.2	-2.9ss	74.6	74.8	70.3	-4.5ss	68.7	69.9	63.3	-6.6ss
	Smoke marijuana occasionally	80.5	88.1	85.7	-2.4ss	83.7	83.6	79.4	-4.2ss	79.4	79.7	75.5	-4.2ss
	Smoke marijuana regularly	92.1	90.8	88.9	-1.9ss	90.4	90.0	87.4	-2.6ss	89.3	90.1	87.6	-2.5s
	Try inhalants once or twice	84.9	84.0	82.5	-1.5s	85.2	85.6	84.8	-0.8	—	—	—	—
	Take inhalants regularly	90.6	90.0	88.9	-1.1s	91.0	91.5	90.9	-0.6	—	—	—	—
	Try LSD once or twice ^c	—	—	90.2	—	—	—	88.6	—	90.1	88.1	85.9	-2.2
	Take LSD regularly	—	—	93.6	—	—	—	93.8	—	95.4	95.5	95.8	+0.3
	Try crack once or twice	91.7	90.7	89.1	-1.6ss	92.5	92.5	91.4	-1.1	92.1	93.1	89.9	-3.2ss
	Take crack occasionally	93.3	92.5	91.7	-0.8	94.3	94.4	93.6	-0.8	94.2	95.0	92.8	-2.2s
	Try cocaine powder once or twice	91.2	89.6	88.5	-1.1s	90.8	91.1	90.0	-1.1	88.0	89.4	86.6	-2.8s
	Take cocaine powder occasionally	93.1	92.4	91.6	-0.8	94.0	94.0	93.2	-0.8	93.0	93.4	91.2	-2.2s
	Try one or two drinks of an alcoholic beverage (beer, wine, liquor)	51.7	52.2	50.9	-1.3	37.6	39.9	38.5	-1.4	29.8	33.0	30.1	-2.9
	Take one or two drinks nearly every day	82.2	81.0	79.6	-1.4	81.7	81.7	78.6	-3.1ss	76.5	75.9	77.8	+1.9
	Have five or more drinks once or twice each weekend	85.2	83.9	83.3	-0.6	76.7	77.6	74.7	-2.9ss	67.4	70.7	70.1	-0.6
	Smoke one or more packs of cigarettes per day	82.8	82.3	80.6	-1.7s	79.4	77.8	76.5	-1.3	71.4	73.5	70.6	-2.9
	Use smokeless tobacco regularly	79.1	77.2	77.1	-0.1	75.4	74.6	73.8	-0.8	—	—	—	—
	Take steroids ^d	89.8	90.3	89.9	-0.4	90.0	91.0	91.2	+0.2	90.5	92.1	92.1	0.0
	Approx N =	17390	18503	18435		14750	14774	15334		2547	2645	2268	

NOTE: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001.
— indicates data not available.

SOURCE: Monitoring The Future Study, The University Of Michigan

^aAnswer alternatives were: (1) Don't disapprove, (2) Disapprove, (3) Strongly disapprove. For 8th and 10th grades, there was another category—"Can't say, drug unfamiliar"—which was included in the calculation of these percentages.

^bThe twelfth grade questions ask about people who are 18 or older.

^c8th and 10th grade: Data based on a single questionnaire form in . N is one-half of N indicated.

TABLE 9
Long-Term Trends in Disapproval of Drug Use by Twelfth Graders

Q	Do you disapprove of people (who are 18 or older) doing each of the following ^a	Percentage "disapproving" ^b																Class of 1975	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	Class of 1988	Class of 1989	Class of 1991	Class of 1992	Class of 1993	change
		1975	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1991	1992																		
	Try marijuana once or twice	47.0	38.4	33.4	34.2	39.0	40.0	45.5	46.3	49.3	51.4	54.6	56.6	60.8	64.6	67.8	69.7	69.9	63.3	-6.6ss															
	Smoke marijuana occasionally	54.8	47.8	44.3	45.3	49.7	52.6	59.1	60.7	63.5	65.8	69.0	71.6	74.0	77.2	80.5	79.4	79.7	75.5	-4.2ss															
	Smoke marijuana regularly	71.9	69.5	65.5	67.5	69.2	74.6	77.4	80.6	82.5	84.7	85.5	86.6	89.2	89.3	89.8	91.0	89.3	90.1	-2.8s															
	Try LSD once or twice	82.8	84.6	83.9	85.4	86.6	87.3	86.4	88.8	89.1	88.9	89.5	89.2	91.6	89.8	89.7	89.8	90.1	88.1	85.9	-2.2														
	Take LSD regularly	94.1	95.3	95.8	96.4	96.9	96.7	96.8	96.7	96.9	96.8	97.0	96.6	97.8	96.4	96.4	96.3	96.4	95.5	95.8	+0.3														
	Try cocaine once or twice	81.3	82.4	79.1	77.0	74.7	76.3	74.6	76.6	77.0	79.7	79.3	80.2	87.3	89.1	90.5	91.5	93.5	92.0	92.7	-0.3														
	Take cocaine regularly	93.3	93.9	92.1	91.9	90.8	91.1	90.7	91.5	93.2	94.5	93.8	94.3	96.7	96.2	96.4	96.7	97.3	96.9	97.5	+0.6														
	Try crack once or twice	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	92.3	92.1	93.1	89.9	-3.2ss													
	Take crack occasionally	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	94.3	94.2	95.0	92.8	-2.2s													
	Take crack regularly	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	94.9	95.0	95.5	93.4	-2.1s													
	Try coke powder once or twice	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	87.9	88.0	89.4	86.6	-2.8s													
	Take coke powder occasionally	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	92.1	93.0	93.4	91.2	-2.2s													
	Take coke powder regularly	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	93.7	94.4	94.3	93.0	-1.3													
	Try heroin once or twice	91.5	92.6	92.5	92.0	93.4	93.5	93.5	94.6	94.3	94.0	94.0	93.3	96.2	95.0	95.4	95.1	96.0	94.9	94.4	-0.5														
	Take heroin occasionally	94.8	96.0	96.0	96.4	96.8	96.7	97.2	96.9	96.9	97.1	96.8	96.6	97.9	96.9	97.2	96.7	97.3	96.8	97.0	+0.2														
	Take heroin regularly	96.7	97.5	97.2	97.8	97.9	97.6	97.8	97.5	97.7	98.0	97.6	97.6	98.1	97.2	97.4	97.5	97.8	97.2	97.5	+0.3														
	Try amphetamines once or twice	74.6	75.1	74.2	74.8	75.1	75.4	71.1	72.6	72.3	72.8	74.9	76.5	80.7	82.5	83.3	85.3	86.5	86.9	84.2	-2.7s														
	Take amphetamines regularly	92.1	92.8	92.5	93.5	94.4	95.0	91.7	92.0	92.6	93.6	93.3	93.5	94.2	94.2	95.5	96.0	95.6	96.0	+0.4															
	Try barbiturates once or twice	77.7	81.3	81.1	82.4	84.0	83.9	82.4	84.4	83.1	84.1	84.9	86.8	88.6	89.4	89.3	90.5	90.6	90.3	89.7	-0.6														
	Take barbiturates regularly	93.3	93.6	93.0	94.3	95.2	95.4	94.2	94.4	95.1	95.1	95.5	94.9	96.4	95.3	95.3	96.4	97.1	96.5	97.0	+0.5														
	Try one or two drinks of an alcoholic beverage beer, wine, liquor	21.6	18.2	15.6	15.6	15.8	16.0	17.2	18.2	18.4	17.4	20.3	20.9	21.4	22.6	27.3	29.4	29.8	33.0	30.1	-2.9														
	Take one or two drinks nearly every day	67.6	68.9	66.8	67.7	68.3	69.0	69.1	69.9	68.9	72.9	70.9	72.8	74.2	75.0	76.5	77.9	76.5	75.9	77.8	+1.9														
	Take four or five drinks nearly every day	88.7	90.7	88.4	90.2	91.7	90.8	91.8	90.9	90.0	91.0	92.0	91.4	92.2	92.8	91.6	91.9	90.6	90.8	90.6	-0.2														
	Have five or more drinks once or twice each weekend	60.3	58.6	57.4	56.2	56.7	55.6	55.5	58.8	56.6	59.6	60.4	62.4	62.0	65.3	66.5	68.9	67.4	70.7	70.1	-0.6														
	Smoke one or more packs of cigarettes per day	67.5	65.9	66.4	67.0	70.3	70.8	69.9	69.4	70.8	73.0	72.3	75.4	74.3	73.1	72.4	72.8	71.4	73.5	70.6	-2.9														
	Take steroids	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	90.8	96.5	92.1	92.1	0.0													
	Approx. N =	2677	2957	3095	3086	3221	3261	3610	3651	3341	3254	3265	3113	3302	3311	2799	2566	2547	2645	2208															

Approx. N =

2677

2957

3055

3686

3221

3261

3610

3651

3341

3254

3245

3113

3302

3311

2799

2566

2547

2645

2268

NOTE: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. '—' indicates data not available.

SOURCE: Monitoring The Future Study, The University Of Michigan.

^aAnswers: 1=Disapprove, 2=Disapprove, and 3=Strongly disapprove. Percentages are shown for categories (2) and (3) combined.^bThe 1975 question asked about people who are 20 or older.

TABLE 10

**Trends in Perceived Availability of Drugs
Eighth, Tenth, and Twelfth Graders, 1991-1993**

	Percentage saying "fairly easy" or "very easy" to get ^a									
	8th Grade		10th Grade		12th Grade					
	1992	1993	'92-'93 change	1992	1993	'92-'93 change	1992	1993	'92-'93 change	
<i>Q How difficult do you think it would be for you to get each of the following types of drugs, if you wanted some?</i>										
Marijuana	42.3	43.8	+1.5	65.2	68.4	+3.2ss	82.7	83.0	+0.3	
Crack	25.6	25.9	+0.3	33.7	33.0	-0.7	43.5	43.6	+0.1	
Cocaine Powder	25.7	25.9	+0.2	35.0	34.1	-0.9	48.0	45.4	-2.6	
LSD	21.5	21.8	+0.3	33.6	35.8	+2.2	44.5	49.2	+4.7ss	
PCP ^b	18.0	18.5	+0.5	23.7	23.4	-0.3	31.7	31.7	0.0	
Heroin	19.7	19.8	+0.1	24.3	24.3	0.0	34.9	33.7	-1.2	
Other Opiates ^b	19.8	19.0	-0.8	26.9	24.9	-2.0	37.1	37.5	+0.4	
Amphetamines	32.2	31.4	-0.8	43.4	46.4	+3.0s	58.8	61.5	+2.7	
Crystal Meth. (Ice) ^b	16.0	15.1	-0.9	18.8	16.4	-2.4s	26.0	26.6	+0.6	
Barbiturates	27.4	26.1	-1.3	38.0	38.8	+0.8	44.0	44.5	+0.5	
Tranquilizers	22.9	21.4	-1.5	31.6	30.5	-1.1	40.9	41.1	+0.2	
Cigarettes	77.8	75.5	-2.3ss	89.1	89.4	+0.3	—	—	—	
Alcohol	76.2	73.9	-2.3ss	88.6	88.9	+0.3	—	—	—	
Steroids	24.0	22.7	-1.3	37.6	33.6	-4.0ss	46.8	44.8	-2.0	
Approx N =	8355	16775		7014	14652		2586	2670		

NOTES: Level of significance of difference between the two years. s = .05, ss = .01, sss = .001.
— indicates data not available.

SOURCE: Monitoring The Future Study, The University Of Michigan.

^aAnswer alternatives were: (1) Probably impossible, (2) Very difficult, (3) Fairly difficult, (4) Fairly easy, (5) Very easy. For 8th and 10th grades, there was another category—"Can't say, drug unfamiliar"—which was included in the calculation of these percentages.
^b8th and 10th grade only: 1993 data from one questionnaire form only. N is one-half of N indicated.

TABLE 11
Long-Term Trends in Perceived Availability of Drugs, Twelfth Graders

Q.	Percentage saying "fairly easy" or "very easy" to get*																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	
	Class of 1975		Class of 1976		Class of 1977		Class of 1978		Class of 1979		Class of 1980		Class of 1981		Class of 1982		Class of 1983		Class of 1984		Class of 1985		Class of 1986		Class of 1987		Class of 1988		Class of 1989		Class of 1990		Class of 1991		Class of 1992		Class of 1993		Change																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
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How difficult do you think it would be for you to get each of the following types of drugs, if you wanted some?																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																		

NOTE: Level of significance of difference between the two most recent classes: $s = .05$, $ss = .01$. '—' indicates data not available.

SOURCE: Monitoring The Future Study, The University Of Michigan.

*Answer alternatives were: (1) Probably impossible, (2) Very difficult, (3) Fairly difficult, (4) Fairly easy, and (5) Very easy.

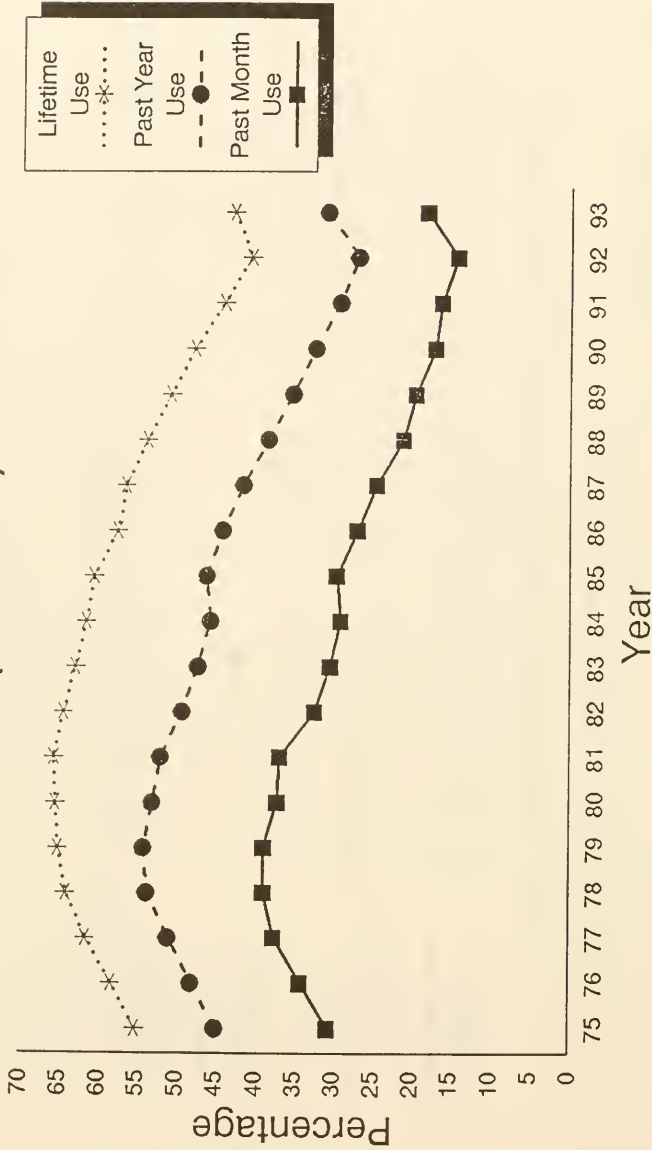
TABLE 2

Sample Sizes and Response Rates

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	
<i>Twelfth Grade</i>																				
Number public schools	111	108	108	111	111	107	109	116	112	117	115	113	117	113	111	114	117	120	121	
Number private schools	14	15	16	20	20	20	19	21	22	17	17	16	18	19	22	23	19	18	18	
Total number schools	125	123	124	131	131	127	128	137	134	134	132	129	135	132	133	137	136	138	139	
Total number students	16,791	16,678	18,436	18,924	16,662	16,624	18,267	18,348	16,947	16,499	16,502	16,713	16,843	16,795	17,142	18,676	15,483	16,261	16,763	
Student response rate	78%	77%	79%	83%	82%	82%	81%	83%	84%	83%	84%	83%	83%	84%	83%	86%	83%	84%	84%	
<i>Tenth Grade</i>																				
Number public schools	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	107	106	111	
Number private schools	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	14	19	17	
Total number schools	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	121	125	128	
Total number students	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	14,946	14,997	16,616	
Student response rate	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	87%	88%	86%	
<i>Eighth Grade</i>																				
Number public schools	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	131	153	126	
Number private schools	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	31	26	30	
Total number schools	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	162	159	156	
Total number students	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	17,844	19,015	18,830	
Student response rate	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	90%	90%	90%	

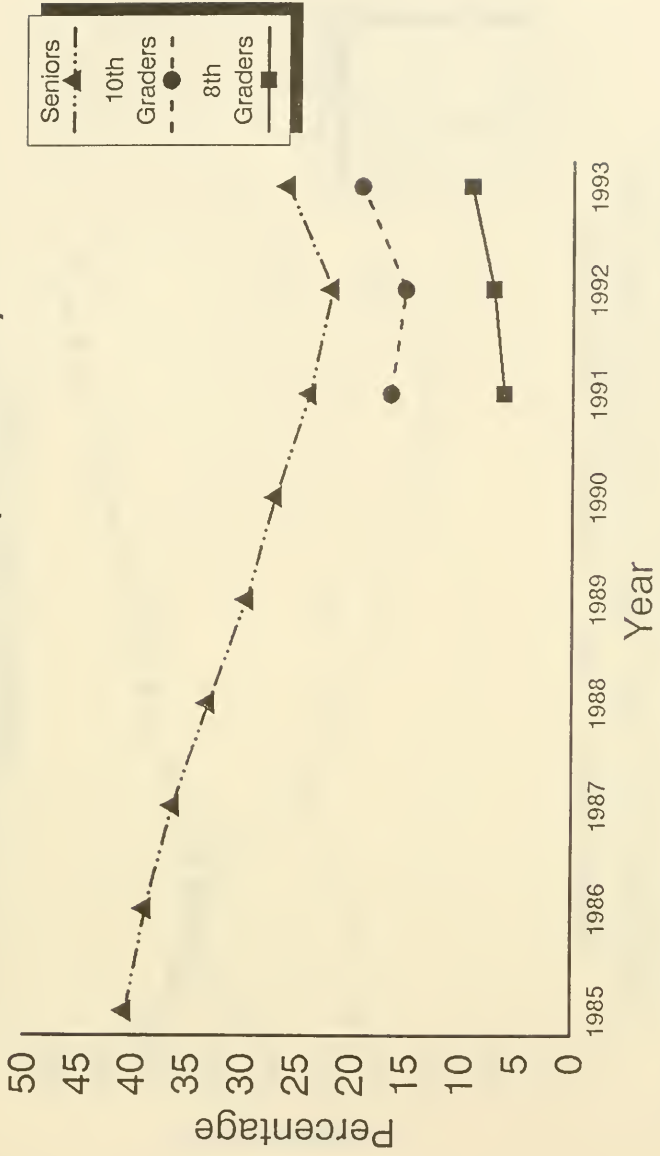
SOURCE: The Monitoring the Future Study, the University of Michigan

Trends in Prevalence for Any Illicit Drug Use for Seniors: Lifetime, Past Year, Past Month (1975-1993)



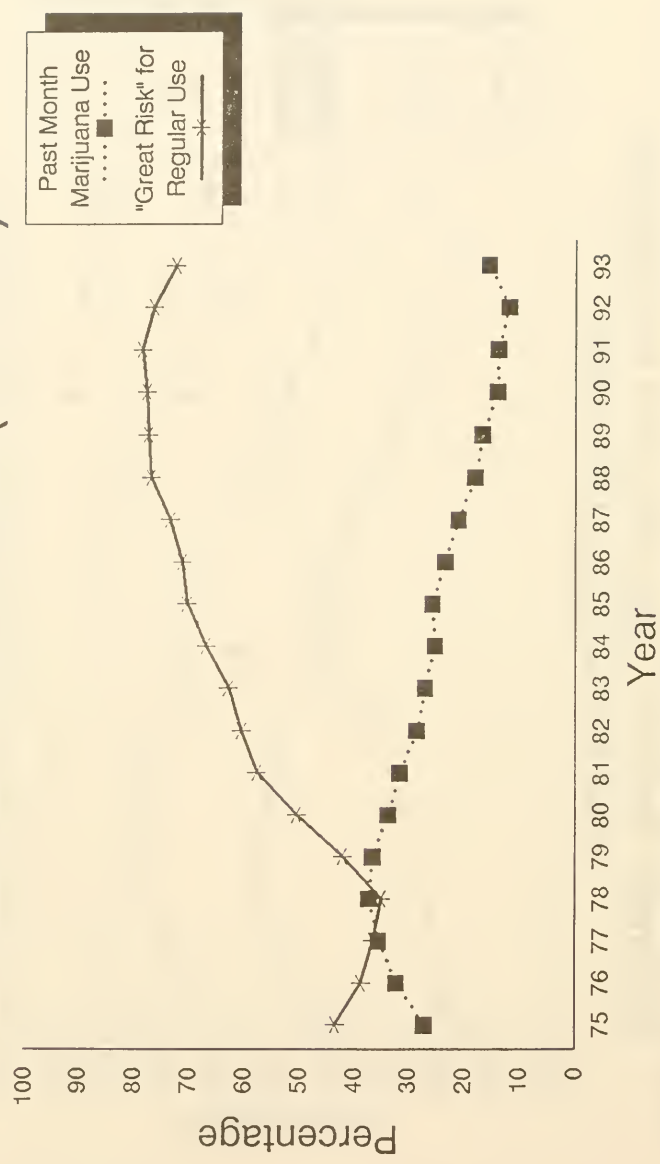
Source: Monitoring the Future Study, 1993

Trends in the Past Year Use of Marijuana by Grade: Seniors (1985-1993) and 10th Graders and 8th Graders (1991-1993)



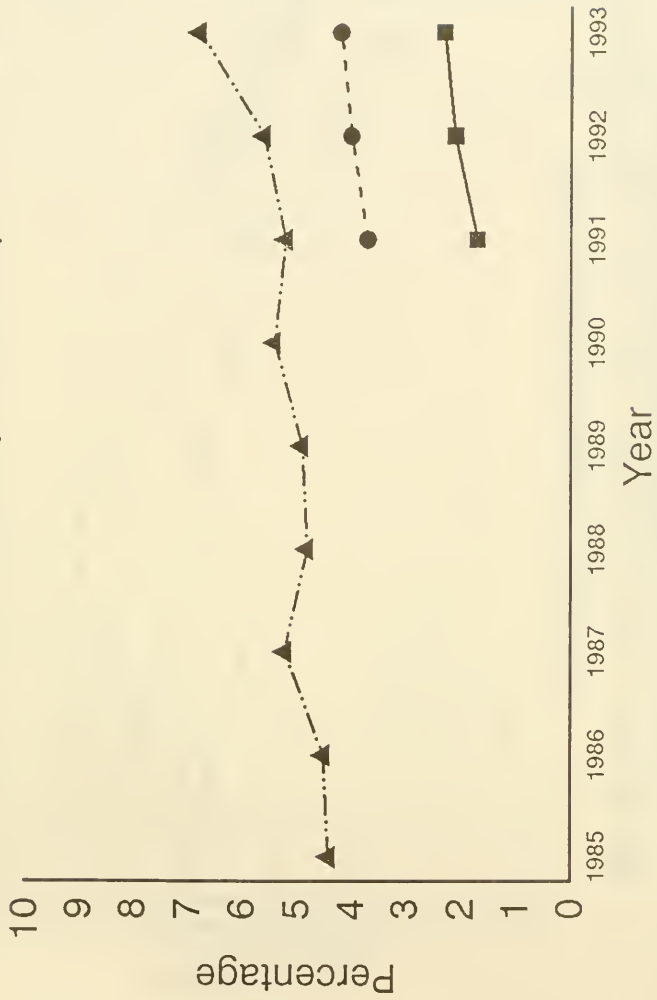
Source: Monitoring the Future Study, 1993

Trends for Seniors: Past Month Use of Marijuana and the Belief that Regular Marijuana Use is a Great Risk to User's Health (1975-1993)



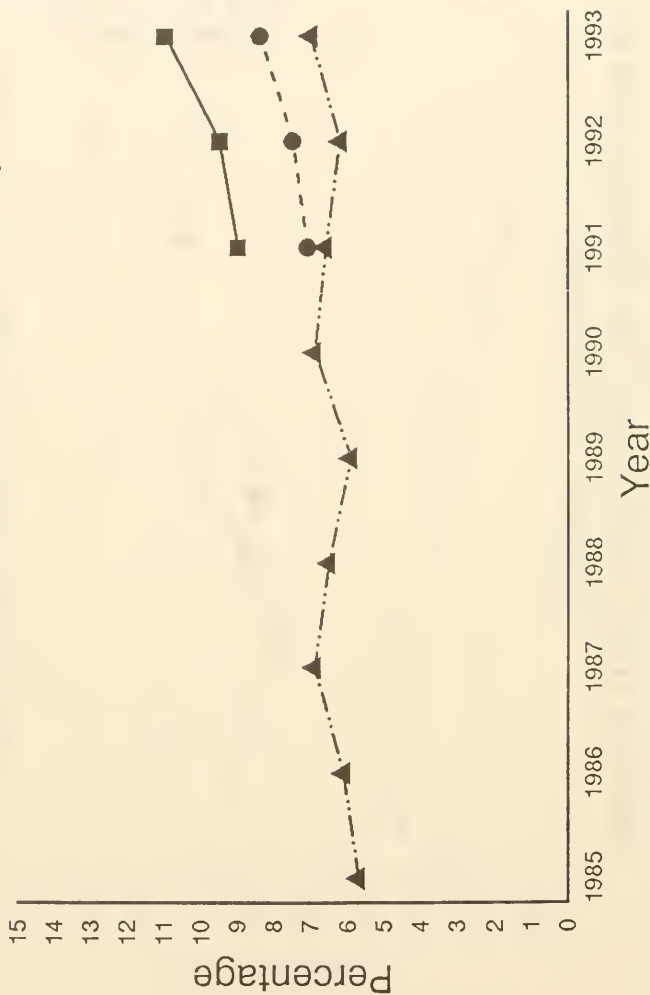
Source: Monitoring the Future Study, 1993

Trends in the Past Year Use of LSD, by Grade: Seniors (1985-1993) and 10th Graders and 8th Graders (1991-1993)



Source: Monitoring the Future Study, 1993

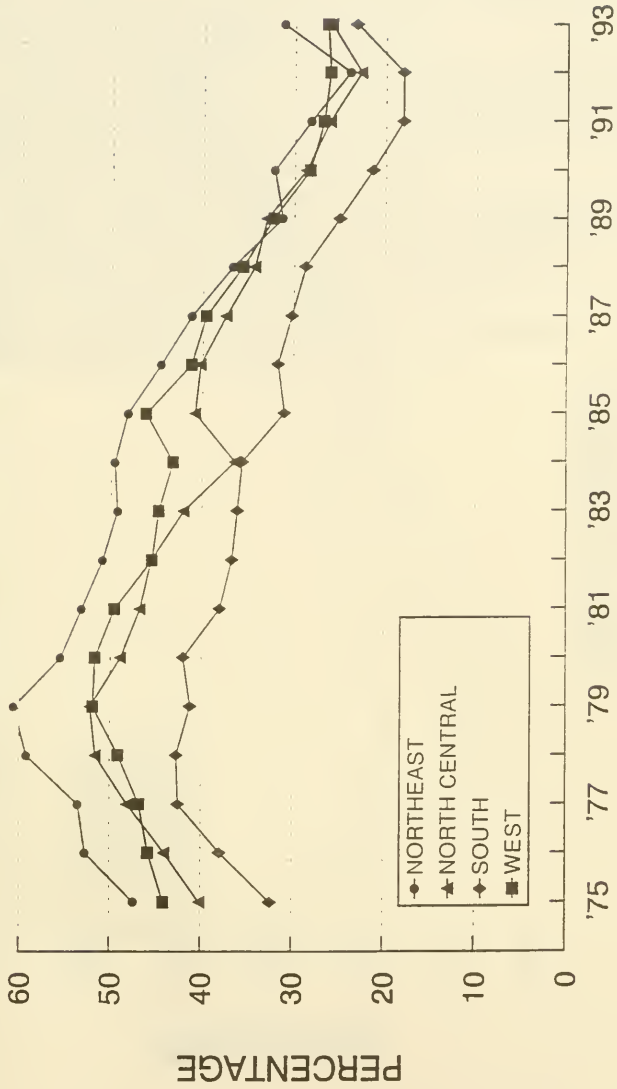
Trends in the Past Year Use of Inhalants by Grade: Seniors (1985-1993) and 10th Graders and 8th Graders (1991-1993)



Source: Monitoring the Future Study, 1993

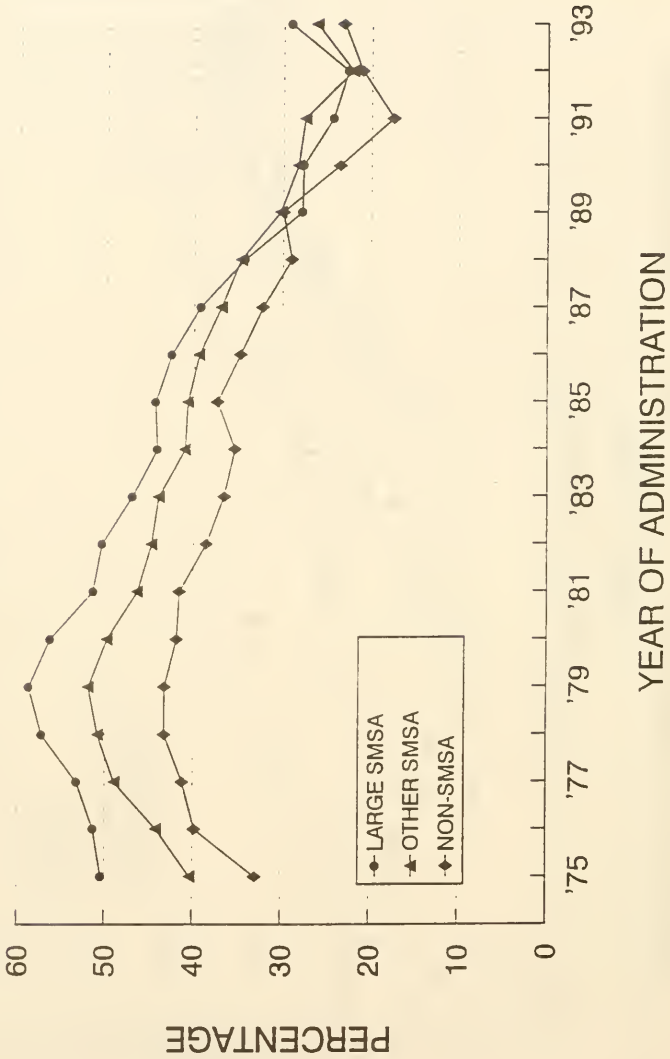
TRENDS IN ANNUAL PREVALENCE OF MARIJUANA BY REGION

TWELFTH GRADERS



YEAR OF ADMINISTRATION

TRENDS IN ANNUAL PREVALENCE OF MARIJUANA BY URBANICITY TWELFTH GRADERS



Mr. CONDIT. Thank you Ms. Sloboda, and I would love to have the opportunity to ask you questions. I have 4 minutes to go and vote. I really feel bad about shortchanging you.

I have a series of questions I would like to mail to you and ask that you respond in writing, and we will add those to the record. I particularly have some questions for Mr. Haislip about the methadone program which I think are very important, and I once again apologize. This is a very important issue to us.

We have been at this almost 4 hours today. I stretched it a little bit beyond what I probably should have, and I apologize for the delay and making you wait and all that. But you have been very helpful, and we will get the questions in writing to you.

Thank you. The hearing is adjourned.

[Whereupon, at 1:20 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]



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